or Attending Physician; The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. To the Hospita. ...
within 24 hours after death.
To the Funeral Director. After this

> State Registrar

Medical

29a. Certifier

30. Name and

(Check only one)

29b. Signature and title of ertifier

M.D., 52 WATER ST. 2007

ss of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

IHURMONT, MD.

29d. Date signed (Month, Day, Year)

21788

		1- State of Maryland / Department	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2007 29502
Physici /Medic		1. Decedent's Name (First, Middle, Last) Rachel Alice Voshell	2. Date of Death August 28 2007 3. Time of Death 11:15P M
Examir	er	4a. Facility Name (If not institution, give street and number) Union Hospital	4b. City, Town, or Location of Death Elkton Cecil
Funeral Director		5. Social Security Number 221-10-9969 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthda yrs. 7. Age (In yrs. last birthda yrs.)	(Months Days Hours Min. January 23 1915 Maryland Months Days Hours Min. January 23 1915 Maryland
e Maryland Ba-f show tifted at	ctor	10a. State	_ocation 10d. Inside City Limits 1 □ No
ath with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 1 Price Dr.	10f. Zip Code 10g. Citizen of What Country? USA
of 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. Ith and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- lif Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2x No Specify: Specify: White
within 72 ho iene. • than "natul the Medical	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation ve kind of work done during most of working DO NOT use retired) Sewife 16b. Kind of Business/Industry Own Home
uld be filed Mental Hygi rrked other rtic event, t	To Be Co	17. Father's Name (First, Middle, Last) Leroy Reynolds	18. Mother's Name (First, Middle, Maiden Surname) Margaret Barrow
and 2 shousalth and N 27 is ma			ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elm Ave. Newark, DE 19711
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Martal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) 21. Size ture of Funeral Serios Licensee	Date 20c. Location - City or Town, State 20c. New Castle, DE 22. Name and Address of Facility Picer-Mullikin FH 1000 N DuPont Pky New Castle
Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or om lications hat caused the death. Do not a shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medical Examiner	Due to (or as a consequence of): d	Teen Failure 23d. Date of delivery Month Day Year
ires that the de signed by the a d be detached to	þ	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 ▼ Probably 4 □ Unknown
The lavate has the	Completed	1 500 110 100 19 110 100 13	24a. Was an autopsy performed? 1
Attending Physicien: The reath. ector: After this certificate by the funeral direc or, pag	Certification: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 28d. Describe how injury occurred
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the lead within 2 To the lead to the le	Medical	29b. Signature and title of certifer Perholes 5 MD	29c. License number Doo23322 29d. Date signed (Month, Day, Year) 8/30/07 29d. Date signed (Month, Day, Year) 8/30/07 29d. Date signed (Month, Day, Year) 8/30/07 29d. Date signed (Month, Day, Year) 8/30/07
2		30. Name and address of person who completed cause of death (Item 23a) (Typ. S. S SAGIDEV MD 118 North	Sy Suite 3B E-Ck Cm MD 2/921.
Sta Regist		31. Date filed (Month, Day, Year) AUG 3 0 2007	Sparle

State of Maryland / Department of Health and Mental Hygien ? [] [] 7

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Mark Nathan Wadel August 28, 2007 3:42 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospice Dove House Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 MM 2 □ F 67 Yrs. 181-32-2778 Sep 30, 1939 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location or 28a-f show the Medical Examiner must be notified at Westminster Maryland Carroll 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1414 Old Manchester Road 21157 USA iteme 23a Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Planning Owner/Operator 10 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Imporant: if Item 27 is marked oth any lightly or other traumatic event once. Emma Shetter Harry Samuel Wadel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 Old Manchester Road, Westminster, MD 21157 Betty A. Wadel, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/31/2007 Westminster, MD Meadow Branch Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 ust. K Approximate Interval Between Onset and Death 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** etusta /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to minimaliate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) sete hes been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2HNo 1 Yes Division of Vital or Attending Physician: director, Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specifical Specifical Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funarai Director: A completely filled in by the fu М investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number WJL Middleton and address of person who completed cause of death (Item 23a) (Type, Print) 10 Rd, Westminster, MD middleton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 29 2007 Registrar

			For State	State of	Marylan					and M	ental Hy	giene				
_	_		Registrar			Cei	rtificate	of L	Death			Reg. No.	20	07	29	504
	Physici	an	1. Decedent's Name (First, Middle, Brena U.	Last) Whitte	n						Date of De Month	ath Day	,	Year	3. Time	of Death
1	/Medi		brena U.	WIIICCE	:11						August	28,	200	7	5:45	ам
	Examir	er	4a. Facility Name (If not institution,	give street and numb	per)		4b. City, T	own, or	Location o	f Death		4c.	County o	f Death		
			17350 Quaker La	ne, Havilar	d Hall,	Rm. 121	If the dead				Spring				gomer	
П	Funeral	ļ		6. Sex 7 1 ☐ M 2 😾 F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th i <i>y, Y</i> ea <i>r)</i>		9. Birthp Cour	olace (State ntry)	or Foreign
	Director		215-38-5640	*	9	6					Nov. 1	, 19	10	Penn	sylva	nia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	I0d. Inside	City Limits
	laryl sho ed a	5	, i													s 2 No
	the N	Director	Maryland Monto	gomery	S	andy S	pring 10f. Zip (nda.				10a Citi	izen of Wh	nat Cour		ж.
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	₫		77	3 77. 33	n 10	1							iat Cour	iu y :	
	eath	Funeral	17350 Quaker I	12. Was Deced				208		ain? (Cna	cify Yes or No		USA 14. Race	- Amorio	an Indian	
	iter d	Ë	1 ☐ Never Married 2 ☐ Marrie	Armed Force	es?	3.	If Yes, specif	fy Cuba	n, Mexican	, Puerto	Rican, etc.)	-		White,		
36	rs af I', or xaml	by F	3 Widowed 4 □ Divorced	d 1 ☐ Yes 2 If Yes, Give Year or Date	XIII		1 ☐ Yes 2	☑ No	Specify:			1	Specify:	Whi	.te	
21215-0036	tura al E	ed	15. Decedent's			16a. Deced	dent's Usual	Occupa	ition			16h Ki	ind of Bus	iness/In	dustry	
5	in 72 n "nat	Completed	(Specify only highest	grade completed)		(Give	kind of work DO NOT use	c done d	urina most	of worki	ng	105.11			dayay	
12	within jene. than "	E	Elementary/Secondary (0-12)	College (1-4	lor 5+)		Chui	rch	Organ	nist	,	Musi	c Per	rfor	mance	
	e filed y al Hygie other vent, th	Be C	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	, Maiden	Surname)		
an	should be nd Mental marked o Imatic eve	To B	Thomas Uber						Rehe	cca	Brenam	on				
Maryland	shound Mind Mind Mind	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailin	ng Address (Street a			I Route Numb		or Town. S	tate. Zic	Code)	
S	od 2 sulth an 27 is r trau		John C. Whitten			1					ingtow				,	
Ĝ,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			Place of Dispo	sition (Name	e of			ate				own, State	
9	0 0 		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (<i>Sp</i>		ate Par	emetery, crer klawn	natory or otr Memori	ner piace i al	Park	Sept	. 1,					
Baltimore,	4.世紀ラー		21. Signature of Funeral Service L	**		22	2. Name and	Addres	s of Facility		007	Roc	kvil'	le,	Maryl	and
Ba	Depa Impo any Ir		/ Lugho	100	le-						Funera					
	-		23a, Part1. Enter the disease, or o	complications that cau	sed the death	n. Do not ent	OO Uni	of dving	sity Lauchas	Blvd cardiac o	r respiratory a	Silv	er Sp	orin	Approxim	20901 ate
la.			23a. Part1. Enter the disease, or on shock, or heart failure. List of immediate Cause (Final	nly one bause on eac	ch line.			-, -,	,,			.,,			Interval B Onset and	etween
	Physician / /Medical		disease or condition resulting in death)		rdial		tion									
	Examiner			Due to (or	as a consequ	uence of):										
1		<u></u>	Sequentially list conditions,	b. Due to (or	as a consequ	uence of):								_		
	ted nsit	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 10 (0.	ao a conceq.	aciioo oij.										
	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):								-		
8760,	be e sician burit	alE														
387	(1)	dical		d										-+		
×	death certif e attending id for use as	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ency										
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	th 2 ∏ Feta nt at time of d	Ideath 3	Ectopic pre					1	23d. Date Mont		ery Day	Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknow		eath 5L	Other (spe	ciry)								
Δ.	law requires that the death certif as been signed by the attending 2 should be detached for use a:	Ph	Part II. Other significant condition	s contributing to dea	th hut not resi	ulting in the ur	nderlying cau	use nive	n in Part I		23e Did t	obacco i	ise contrib	uite to ti	he cause of	f death?
ds,	signe signed d be	by	, and the second	3			,	3							ably 4X	
or Vital Record	w requir been si should	Completed									-					
ĕ S	e law has b	du							_		24a. Was autoj	psy	pri	ior to co	psy finding mpletion of	s available cause of
=	Th Sate pag	Son									perfo	rmed? 2 🛣 No	1 de	ath? ∃Yes	2□No	
/Ita	ding Physician: Th. n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)				
7	Physic this c	၉	1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatien	t 3 DOA	Othe	r: 4 🗆 Nur	rsing Hor	ne 5 🔀 Resi	dence	6 □Other	(Specit	(y)	
_	aling P	:io	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28	c. Injury Work	at ?	2	28d. Describe	how injur	y occurre	b		
<u> </u>	Attending r death. ector: After oy the funer	ätic	2 Accident investiga				M	1 🗆 Y	'es 2 □ N	No						
Division	or Atten after death Director: in by the	ij	3 Suicide 6 Could no 4 Homicide determin	Zoe. Flace o	f injury - At ho , etc. <i>(Specif</i>)	ome, farm, stre	eet, factory,	office		2	28f. Location (: City or Tox	Street an vn. State	d Number	or Rura	al Route Nu	ımber,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:								1			,			
	e Hospital 24 hours a e Funeral I letely filled	edical	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physician: To the b xaminer: On the bas	est of my kno	wledge, death	n occurred a	t the tim	e, date an	d place, a	and due to the	cause(s)	and man	ner as s	tated.	(8)
	the I	edi	one)	and manne	r stated.					500011	Jac uro urre,	Jule all	, piace, di	ia aue l		
	To With	Σ	29b. Signature and title of certifier	λ			29c.		number 9 793				_		Day, Year)	
	20		1 Clurka	Jacque	W			ינט	J 1 J 3		- Park	Al	ugust	. 28	, 200	,
	12		30. Name and address of person w													
			Christopher J. M				Phili	p D:	rive,	01n	ey, MD	208	32			
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signa	ture	a Aff									

To the I within 2 To the I State Registrar

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) AUG 3 0 2007

Syed A Sadiq, MD

29b. Signature and title of certifier

(Check only one)

14333 Laurel Bowie Road 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

completely

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0024721

Suite 208

29d. Date signed (Month, Day, Year) August 28,07

Laurel , MD 20708

07-06708

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29506

tobert Keith Willis,	lr. I- For State	State of Maryland /	Departmen Certificate	t of Health and e of Death	Mental I		g. N o.	2007	2951
Dhysician	Registrar 1. Decedent's Name (First,	Middle,Last)		, <u>, , , , , , , , , , , , , , , , , , </u>		2. Date of Deat	1	3. Time o	
Physician/ Examiner		eith Willis	Jr			Month August 29	2007 4c. County o	1030	nrs
	4a. Facility Name (if not ins	stitution, give street and number)		4b. City, Town, or Silver Spring		ath	Montgon		
	3323 Weeping W		4			irs. 8. Date of Bir	1	9. Birthplace (S	ate or
Funeral Director	5. Social Security Number unknown	6. Sex 7. Age	(In yrs. last birthda 48	Months Days			/1959		w York
	Usual Residence of Deced	dent						10d. Insi	de City Limits
v any	10a. State 10b. Co	*****	10c. City, Town or	r Spring				1Y	es 2 X No
and Show		ontgomery	21146	1 Spi Ing		1	0g. Citizen of WI	nat Country?	
the Maryland or 28a-f shriffed at once	10e. Street and Number		a. "24				USA		
th the 23 a or		eping Willow	Ct.#34	20906 3. Was Decedent of His	spanic Origin?	(Specify Yes or No	- 14. Race	- American India	n, Black,
or items 23	11. Marital Status 1 X Never Married 2	Married Armed Forces?		If Yes, specify Cubar	n, Mexican, Pue	erto Rican, etc.)	White	e, etc. Whit	
erdez	3 Widowed 4	Divorced If Yes, Give Year	X No	1 Yes 2 X No			Specify:		-
urs aft tural" amine	45 Decedent's Education	n (Specify only highest grade con	npleted) 16a. De	ecedent's Usual Occupa	tion (Give kind	of work done · retired) -	16b. Kind of Bu	usiness/Industry	
5 72 ho n "na al Ex	Elementary/Secondary	(0-12) College (1-4 or	5+)	mputer Ar		100 31	Comp	uter	
5-0036 d within 72 hour lygiene. other than "nature Medical Exan	12			mpucci in		ame (First, Middle,	_		
Hygin doth	17. Father's Name (First,	Keith Willis	Sr.			thy Joan			
2121 Ild be fil Mental H marked event,	19a. Informant's Name/Re		19b.	Mailing Address (Stre	et and Number	or Rural Route Nu	mber, City or Tov	vn, State, Zip	566
2 shour and 1 is and 1 is and 1 is a remarking	Joe Potts			714 Pine			lant Ci	-City or Town, S	rıda
e, N and and Health item	20a. Method of Dispositio	on .	cremator	Disposition (Name of cory or other place)		Date			
nt of l		remation • 3 Removal from St	"" Chesa	peake Cre		/05/200			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filter 27 is narked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Sign re of Funeral	Se Censee Cut A cease, or complications that cause		22. Name and Addre	s of Facility	LDI FUN	ERAL SI	ERVICE,	P.A.
© Fagariti	Xule Of	tueler		9241 Co	umbia	BLvd.S	ilver S	Spring.	Md2091 eximate Interval
> ~'ysician	23a. Part I. Farter the dise					iac or respiratory a	1000, 511000, 611	Betw	een Onset and Death
ledicalkaminer	Immediate Cause (Final	disease a. Atheroscle		ovascular dis	ease	15 m			
ZXXIIIIO	or condition resulting in o	Due to (or as a cons	sequence of):			• •			
	Sequentially list condition if any, leading to immediate	ate Due to (or as a con:	sequence of):		-	5.1			
ed nsit	cause. Enter Underlying (Disease or injury that in	g Cause hitiated c. Due to (or as a con:	sequence of):						
ed nsit	events resulting in death	n) Last Due to (or as a con-	sequence ory.						
e executed ician and urial - transi	XUNPENDED	AMENDED 7	orMF 0871	9/15/07 TT					
50, te be o			ome of pregnancy	7/15/01 11			23d. Date		Year
Vital Records, P.O. Box 68760, selian: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	1 FEMALE: 23b. Was decedent pregipast 12 months? 1 Yes 2 No 9 Part II. Other significant		2 at time of death	, clai deali	Ectopic p	regnancy	Month	Day	i ca
OX 6	1 Yes 2 No 9		at time of death 5	Other (Specify)					
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternormal Director and a funeral director, page 2 should be detached for unapletely filled in by the funeral director, page 2 should be detached for unapletely filled in by the funeral director, page 2 should be detached for unapletely filled in by the funeral director, page 2 should be detached for unapletely filled in by the funeral director, page 2 should be detached for unapletely filled in by the funeral director.	Part II. Other significan	nt conditions contributing to de	ath but not resulting	g in the underlying caus	e given in Part			ntribute to the cau	
P.O. es that the igned by be detach	3					_ [1_]`	res 2 No		
ds, equire						24a. W au	topsy	 Were autopsy f prior to comple 	indings available ion of cause of
Soro law re has by	<u> </u>					pe	rformed?	death? 1 ✓ Yes	2 No
Rec The ficate	5			26.PI	ace of Death (C	Check only one)			
Ital Ician: certi	25. Was case referred t examiner?	Hospital:	itient 2 ER/0	utpatient 3 DOA	200	Nursing Home 5	Residence	Other: Scen	e
Division of Vital Records, tal or Attending Physician: The law requirers after death. The The Third is certificate has been is led in by the funeral director, page 2 should be in by the funeral director, page 2 should be	27 Manner of Death	28a, Date of I	njury 28b.	Time of Injury 28c.	njury at Work?	28d. Descri	be how injury occ	curred	
tending Phreat.	1 X Natural 5		y,Year)	1	Yes 2				
isic Atter er dea rector	2 Accident	Investigation 28e. Place of	f Injury - At home, f	arm, street, factory, offic	e building, etc	. 28f. Locatio	n (Street and Nu n, State)	mber or Rural Ro	ute Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	L Suicide	determined (Specify)				1			
Hospi 24 hou Funei tely fi		rtifying Physician: To the best o	f my knowledge, de	eath occurred at the time	e, date and place	ce, and due to the d	ause(s) and mar	nner as stated. nd due to the cau:	se(s)
To the Hos within 24 h To the Fur completely	0	rtifying Physician: To the best of dical Examiner: On the basis of e and manner state	examination and/or ed.			uned at the time, o	Tood Dates	signed (Month, D	av.Year)
F 3 F 8		e of certifier			ense number		1	30, 2007	. ,
	Dona	mu) incendi, m	, C.	0	.C.M.E.				
1		of person who completed cause	of death (Item 23a)	r 111 Penn Str	aet Raltimo	re MD 21201			
1	Donna M. Vind	centi, MD Assistant Me	dical Examine	i iii Penn Str	sei, pailiille	110, IVID 2 1201			
	te 31. Date filed (More)	PP, Y1 ar 0 2007 32. Fegi	strar's Signature						

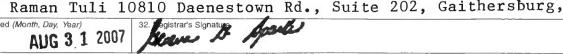
07-06888 Gerald T Zook

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29507

		or State		Cert	ificate of	Death					Reg. No).	(5.4
Physician/	1.1	nistrar Decedent's Name (First, Middl							1 -	Date of De Month Septemb	Day	Year 2007	3. Time of Death 1742 hrs
e ` Examiner		Gerald Than Facility Name (if not institute)	ne Zook on, give street and nu	mber)	4	b. City, Tow				- Органия	4	c. County of De	
		12814 Flack Street				Silver S			24110	9 Date of F	1	Montgomen	Birthplace (State or
Funeral Director	5.	Social Security Number 219-84-1775	6. Sex	7. Age (In yrs. la	st birthday) 45 Yrs.	If Under 1	Days	If Under Hours	Min.			, 1961	reign Maryland Country
		sual Residence of Decedent		10c City	Town or Locati	on							10d. Inside City Limits
ow any	1					Silve	r Si	princ	7				1 Yes 2 X No
the Maryland or 28a-f sh iffied at once	10	aryland e. Street and Number	Montgo	ier y		10f. Zip C				1, F	10g. C	itizen of What 0	Country?
h the Ma 3a or 28 otified		12814 Flack	Street			1	209					SA	
r death with the Maryland or items 13a or 28a-f show must be notified at once.	11	. Marital Status		cedent Ever in U. orces?	S. 13. Wa	s Decedent es, specify	of Hisp Cuban,	anic Ong Mexican,	in? (Spe Puerto F	ecify Yes or Rican; etc.)	No-	14. Race - Al White, et	merican Indian, Black, ic.
or ite	1		1 Yes	2 X No	1	Yes 2	No	specify:				Specify: Wh	nite
215-0036 be filed within 72 hours after death with the Maryland mall Hygiens had released to or 28a-f she ent. the Medical Examiner must be notified at once the controlled by Firmeral Director	5	Widowed 4 Di 15. Decedent's Education (Sp.	or Dates:		16a Deceder		ccupatio	on (Give l	kind of w	ork done	16b	. Kind of Busine	ess/industry
5-0036 ad within 72 hour lygiene. other than "natu he Medical Exan		Elementary/Secondary (0-12) College (1-4 or 5+)	Self-I							Construc	ction
5-0036 Ited within 72 Hygiene. I other than " the Medical of the M		12 7. Father's Name (First, Middle	a Last)		DCII .	- Inp 10 j					e, Maid	en Surname)	
215-(be filed and Hygerked of the	- 1	7. Fathers Name (First, Middle Eugene Dale_						· V	irai	nia M	. Ma	bry	
212 212 ould be I Menti mark ic even		ga. Informant's Name/Relation	nship (Type, Print)		ı								State, Zip Code)
MD d 2 shc Ith and n 27 is	L		e Zook/Wi	fe	12814 Place of Dispo	4 Flac	k S	tree	t, S			ing, MI	ity or Town, State
of Hea	- 1	0a. Method of Disposition 1 Burial 2XX Crematic	on 3 Removal		crematory or o	ther place)			y. 20	ot. 7	' 7	Alexandı	ria, Virginia
Baltimore, MD 21215-003 permit Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene Important: I filen 27 is marked other the injury or other transafte event, the Med	1	Donation 5 Other 1. Signature of Funeral Service	Specify:						l			Home In	26
Bal permi Depar Impo injur					F"	rancıs OO Uni	J. iver	cor	Blv	d. W.	Si	lver Sp	ring. MD 2090
hysician	- 2	23a. Part I. Enter the disease, failure. List only one caus	se on each line										Dooth
Wedical _xaminer		mmediate Cause (Final diseas	se a. Alcohol	and mixed		hlor, h	enir	amine.	hyd	rocodon	e) i	ntoxicati	on Deau
		or condition resulting in death)	Due to (or as	a consequence	of):								
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		a consequence	of):					+1			
	ΕŢ	cause. Enter briderlying cause (Disease or injury that initiated events resulting in death) Las	Due to for a	a consequence	of):								
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	Medical	X UNPENDED	AMENDE #23a	27.28a-f.	perME.g	871 , 9/	15/0	7 TT			_	23d. Date of d	elivery
8760, tificate be ng physic as the buri		IF FEMALE: 3b. Was decedent pregnant in past 12 months?	n the 1 Liv	s, outcome of pre e birth	2	etal death	3	Ectop	oic pregn	ancy		Month	Day Year
ox 6	sicia		Limite and a limited and a lim	egnant at time of d known	teath 5	Other (Spec	cify)				-		
cords, P.O. Box 68: aw requires that the death certifi has been signed by the attending should be detached for use as	Physician	Part II. Other significant con			resulting in the	e underlying	cause	given in F	Part I.				oute to the cause of death?
P.C es that iigned										1000			Probably 4 Unknown
rds, requirements been should	Completed										Was an autopsy perform	, pr	rior to completion of cause of eath?
ecol he law ate has	E O										Yes 2		Yes 2 No
Vital Rec hysician: The this certificate	BeC	25. Was case referred to med examiner?	dical Hospital:				26.Plac	of Deat		only one)	5 R	esidence 6	Other: Scene
F Vit	2	1 ✓ Yes 2 No 27. Manner of Death		Inpatient 2 ate of Injury	ER/Outpatie			ury at Wo				w injury occurre	
on of or anding Pt. th. r: After	ioi	1 Natural 5 F	Pending Fad	onth, Day, Year) 9/4/2007	Fnd 5:	40 nm	1_	Yes 2	χNο	unk			
ivisic I or Atte after dea Directo	fical	3 Suicide 6 X C	Could not be 28e. F	Place of Injury - At	home, farm, s	treet, factory	, office	building,	etc.	28f. Loca or To	tion (Stown, Sta	reet and Number	er or Rural Route Number, Ci 1verSPring, MD
Spital of tours and filled	Certification:	4 Homicide	determined (Spec	LCOTC	lence	1 . 1 15	. 41	d-4- a-a	-loss 6				
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifyin one) 2 Medical	g Physician: To the Examiner: On the ba	sis of examination	edge, death oc n and/or invest	igation, în m	e time, iy opinid	on, death	occurred	at the time	, date a	nd place, and d	ue to the cause(s)
To the within To the comple	Med	29b. Signature and title of ce	and mann	er stated.				nse numb				29d. Date signe	ed (Month, Day, Year)
		Carol	Ha	Qai			0.0	C.M.E.				September	5, 2007
12/12		30. Name and address of pe	rson who completed	cause of death (It	tem 23a) 111 Pen	n Street	Ralti	more N	/ID 212	201			
1 6		51 5 1 61 1 61 1 1 5 1 V	Assistant Medic	cal Examiner Registrar's Sign		ii Sueet,	Daitil	noie, i	12		-		
St Regist	tate trar			~ B.	Sperk		-						
DHMH 17 Rev 1/2			/	OCME	ORIGI	NAL							

31. Date filed (Month, Day, Year) AUG 3 1 Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20878

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show M800442538

Pages 1 and 2 should

law requires that the death certificate be executed

this certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

Aldrich, Lewi

Division or Vital

of Health

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per Ana Bastate of Many and Sertificate of Death Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 00:39 AM 3, 2007 September Lewis E. Aldrich Jr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 € M 2 □ F 75 Dec 30, 1931 Pennsylvania Director 213-20-4141 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Harford Whiteford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21160 USA 4357A Cooper Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates: 153-61 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 diesel mechanic automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Edwin Aldrich Florence Louise Dougherty 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Aldrich/spouse 4357A Cooper Road Whiteford, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If Its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARdioVascular a Atherosclerofic ten years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) been signed by the sale 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 ■Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NORTH

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

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of Maryland / Department of Health and Mental Hygien 2007	19511	Ĺ

State of 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 0208 4M **Physician** 12 2007 BROOKS SR SEPTEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1**X**]M 2□F Yrs. 1956 Maryland 31, Director 215-56-0148 5 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number S. 21236 3726 Proctor Lane Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic evant, the Madical Elementary/Secondary (0-12) College (1-4or 5+) Steel Compnay Welder 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othin any injury or other traumatic event sons. 17. Father's Name (First, Middle, Last) Be Marie Buzzard Charles Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3726 Proctor Lane, Baltimore, Maryland 21236 Diane M. Brooks (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 109/ 15/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd., Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RIGHT 4 HOURS HEART FAILURE Physician /Medical Due to (or as a consequence of): Examiner HOURS HEART FALLURE LEFT Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit 10 YEARS death certificate be executed CORONARY ARTERY DISEASE and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medicai IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No autopsy performed? 1 ☐ Yes 2 ☑ No this certificate 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ۵ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 -, MD SEPTEMBER 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACHIN SHRIDHARANI GOO NORTH WOLFE STREET BALTIMORE, MARYLAND 21287 12 31. Date filed (Month, Day, Year) SEP 1 4 2007 32. Registrar's Signature weeks! State Registrar

/Medical Examiner requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

item 27 l

attending physician and for use as the bunal-tran certificate has After this To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29c. License number

MD

29d. Date signed (Month, Day, Year) 0

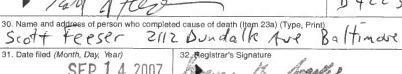
State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

14 SEP 2007



			_ For	State of Ma	ryland / Dep			Mental Hygie	2007	29512
			1 - State Registrar		Се	rtificate of	Death	Reg	. No.	
7.	Physici	an	1. Decedent's Name (First, Middle	Jan 16/	Black	1. 11		2. Date of Death Month	Day Year	3. Time of Death $1 = 25 p_{\text{M}}$
1	/Medic		4a. Facility Name (If not institution	n, give street and number)	Buck		or Location of Death		4c. County of Dea	
			GOOD JAM	AritAN NO	spital	Bal	fi Levie		11/13	
	Funeral		5. Social Security Number		(In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bi	rthplace (State or Foreign ountry)
e e	Director	4	Usual Residence of Decedent		20			DEC. 16,	1796 11	CAMILIAGE
	arylene show	_	10a. State 10b. County	/	10c. City, Town or L					10d. Inside City Limits 10d. Inside City Limits 2 □ No
	the Ma	ecto	10e. Streetland Number	MA	15 A I	101. Zip Code		100	. Citizen of What C	
	be filed within 72 hours after deeth with the Marylend hat Hygiene. of other then "natural", or items 23s or 28s-f show event, I'm Medical Evacificat must be notified at	Funeral Directo	3318 VENU	(4) AUG		2/7/	13	109	USA	ournity:
	deeth	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - Am Black, Wh	
36	s after	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	ned 1 ☐ Yes 2 N	6	1 Yes 2 No		- 11	Specify:	6-
5-0036	2 hour	ted t	15. Deceden	t's Education	16a. Dece	edent's Usual Occup	pation	16	b. Kind of Business	Modustry
215	thin 7:	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5-	life.	B kind of work done DO NOT use retire	during most of work	king	7 .	6. 1
121	filed wi Hygien sther th		17. Father's Name (First, Middle,	4 yems	Lhi	& pector	19 Mather's Nam	no (First, Middle, Ma	Eners !	RUKES
and	should be filed within the Mental Hygiene. marked other then matic event, to a Mental the Mental th	То Ве	~ ~ ~ ~ ~	cckwell			Lillia	~	11	
Mary	permit. Peges 1 and 2 should Department of Health and Men Importent: if Item 27 is marke eny injury or other traumatic once.	-	19a. Informant's Name/Relations	hip (Type, Print)	4	ing Address (Street		ral Route Number, C		Zip Code)
-	1 and 2 Health em 27 i		VALAITE Blo	ECKWELL /W	1/2 331	PKEN	you Aut		LIBIE, 1.	2 2/12/3
more	Peges 1 nent of H int: if ite		20a. Method of Disposition 2 ☐ Cremation			ematory or other pla	ce) /	P//3/12 20	c. Location - City o	1 0
altin	permit. Peg Department Important: I eny Injury o	. 19	4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		FIVESTUS	INE META	ess of Facility	NA THO 192	-MUTUI	
ä	permit. Depart import eny inj	i, 9	V (ulle	Hamo		42/0 /				105/2 12/
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each line	the death. Do not en	nter the mode of dyir	ng, such as cardiac	or respiratory arrest		Approximate Interval Between
Y.	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Severe	Sepsis an	nd Metas	tatie Co	len Canc	er	Onset and Death
	/Medical Examiner			Due to (or as a	consequence of):	Abscess	c			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):	403000				
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760,	te be executed ysicien and he burial-transit	Ical E		Due to (or as a	consequence or).					
89	3 > 6			d						
Box	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		□Ectopic pregnanc	v		23d. Date of de	
о. П	the at	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐ Pregnant at t 9☐ Unknown		Other (specify)	<u></u>		Month	Day Year
α.	The law requires that the death certifics ate has been signed by the attending propage 2 should be detached for use as it		Part II. Other significant condition	ons contributing to death bu	t not resulting in the t	underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute	o the cause of death?
Records,	w requires been sign should be	ed by	End stage 1	Renal Disea	se			1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
eco	ne law re has bee	Completed	Metastas:s	to Lungs	and Liv	er		24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
	sicien: The certificate har rector, page		Diabetes					performe	d? death?	
Ĭ	sicien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:	- /7	Ott	hoe	th (Check only one)		
ō	ng Phys ter this neral dir	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injur	/ 28b. Time o	HIL 3 DOA	4 Nursing H	ome 5 Residence 28d. Describe how		ecify)
ion	Attending Physicien: or death. ector: After this certificaby the funeral director.	atlo	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	gation	Year) Injury		rk?]Yes 2□No			
Division of Vital	or Att	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of Inju- building, etc	ry - At home, larm, st . (Specify)	treet, tactory, office		281. Location (Stree City or Town,		Rural Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyir	ng Physician: To the best o	f my knowledge, dea	th occurred at the til	me, date and place	, and due to the cau	se(s) and manner a	is stated.
	n 24 h	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner stat	examination and/or in	nvestigation, in my d	opinion, death occu-	rred at the time, date	and place, and du	e to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifie			29c. Licens		290	Date signed (Mor	
,		10	Fang Ki				5000		9/8/	
	D	18	30. Name and address of person Good Samar		ath (Item 23a) (Type a/ 560	Print)	Raven 1	Boulevara	Balts	more, MD
6.4	Sta	te	31. Date filed (Month, Day, Year)		r's Signature	all s				7,110

DHMH 17 Rev 1/2001

BLACKWELL, GERALD F.

with the Maryland or pe is 23a c Pages 1 and 2 should be filed within 72 hours after death vertent of Health and Mental Hygene.

ant: If Hem 27 is marked other than "natural", or frems 23s mart; If Hem 27 is marked other than "natural", or other traumatic event, the Medicial Examiner must into other traumatic event, the Medicial Examiner must Baltimore, Maryland 21215-0036 Department of Heal Important: If Item 2 any Injury or other once.

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

r 28a-f show notified at

Director

Funeral

þ

Be Completed

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Physician /Medical Examiner

Physician/Medical Examiner burial-tran signed to Medical Certification: To Be Completed by page 2 should 24 hours after death Funeral Director: filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

4 Donation 5 Other (Specify)	Garde	ns Of Faith C	emetery Sept	13,2007 Ro	sedale, Ma	aryland
21. Signature of Funeral Service License	1= Yadd	EVANS F	Address of Facility UNERAL CHA MATION SEP	ADET.	arford Roa ille,Maryl	
23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the death. e cause on each line.	Do not enter the mode	of dying, such as care	diac or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	NON-SMALL (INOMA OF	LUNG		3½ Mos.
Sequentially list conditions, if any, leading to in reduce cause. Enter Underlying Cause (Disease or injury that initiated events	Dux to (or as a conseque	nine oil):				
resulting in death) Last	Due to (or as a conseque	nce of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic pre		0	23d. Date of delive Month	ery Day Year
Part II. Other significant conditions conf	tributing to death but not result	ing in the underlying car	use given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death? ably 4 □Unknow
				24a. Was an autopsy performed 1 Yes 2 ₹	prior to cor death?	psy findings availab npletion of cause of 2 2 No
25. Was case referred to medical			26. Place of	Death Check onl one		200
examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DO/	Other: 4 Nursin	g Home 5 Residence	6 □Other (Specify	()
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of 28 Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	e, farm, street, factory,	office	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
29a. Certifier 1 X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination	edge, death occurred a n and/or investigation,	t the time, date and p in my opinion, death o	lace, and due to the cause occurred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
29b. Signature and title of certifier		29c.	License number	29d.	Date signed (Month, I	Day, Year)

DHMH 17 Rev 1/2001

State Registrar

within 2

8022 Belair Rd.

M.D.

's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registr

Ba Yin Oung,

31. Date filed (Month, Day, Year)

D001728

September 11, 2007

21236

Baltimore, MD

			For State Registrar	State of M		ertificate of		nd Mental Hy	giene 007	7 29514
	Physici /Medic	al	Decedent's Name (First, Middle, L BERNARD B 4a. Facility Name (If not institution, ga	ERGER		4b. City, Town,	or Location of	2. Date of De Month	Day Ye	007 6:25 PM
*	Funeral Director		5. Social Security Number 6. 217-24-3427	W NURSI/ Sex 7. Ag 1™M 2□F	o (In yrs. last birthday 77 Yrs.		If Under 2	24 Hrs. 8. Date of Bi Min. (Month, Di Jan 28	CARRI orth ay, Year) 3, 1930	Birthplace (State or Foreign Country) unk
	the Maryland 28a-f ahow	ector	Usual Residence of Decedent 10a. State 10b. County MD Carrol 10e. Street and Number	.1	10c. City, Town or I	ocation Airy			10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes ※☐ No
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23c or 28a-f ahow other traumatic avant, it e Madical Exercice trada Le Dullied at	by Funeral Director	4101 Baltimore 11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.Sunk 13		Hispanic Orig ban, Mexican	771 jin? (Specify Yes or No Puerto Rican, etc.)	US	
121215-0036	filed within 72 hou Hygiene. other than "natura ant, it e Madical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Lax	College (1-4or unk	(Giv	edent's Usual Occu e kind of work done DO NOT use retir	e during most ed)	unk of working 's Name (First, Middle	16b. Kind of Busine	ess/Industry unk
, Maryland	1 and 2 should be fi Health and Mental H am 27 is marked ot other traumatic avai	To Be	19a. Informant's Name/Relationship Pleasant View Nu	(Type, Print)		ling Address (Stree	at and Number	r or Rural Route Numb	per, City or Town, Sta	
Baltimore,	permit. Pages 1 s Department of He Important: If Itar any injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 ₩ Other (Special Service Lo	eify) in stat	e	amatory or other pl		Date Board 655 V	20c. Location - City	
8760,	death certificate be executed Exam Medical eattending physician and dor use as the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or construction or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or as b Due to (or as c	d the death. Do not end	Baltimore the mode only problem.	e, MD ing, such as of	21201 cardiac or respiratory a	irrest,	Approximate Interval Between Onset and Dear Williams Approximate Interval Between Onset Interval Betw
.O. Box 68	the death certify the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of Month	f delivery Day Year
ords, P	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause g	iven in Part I.	1_	Yes 2□No 3□	ite to the cause of death?
Vital Records,	The ate h	Be Completed	25. Was case referred to medical examiner?	Hospital:			26. Place	24a. Was auto perf 1 Yes of Death (Check only	prior deat 2 No 1 1	e autopsy findings available r to completion of cause of the the cause of the cause
Division of	Attanding death. ctor: After y the fune	Certification; To	27. Manner of Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not determine	28a. Date of Inju (Month, Date on be 28e. Place of In	ury 28b. Time	of 28c Inju	ury at ork?	No 28f. Location	how injury occurred	or Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	edicai Cer	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner st	of my knowledge, dea of examination and/or	ath occurred at the nvestigation, in my	time, date and opinion, deat	d place, and due to the	cause(s) and manne	er as stated. I due to the cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier	od K	mom	29c. Licer	o b	88 M)	29d. Date signed (V	Nonth, Day, Year)
6	Sta	ite_	30. Name and address of person who (150) and (Month, Ďay, Year)	YMMX	de th (Item 23.) ype Sarr's Signature	(Print) &	licet	+ City	Mis.	21cm
1	Regist	- 3	SEP 14	2007	H.	land o				

DHMH 17 Rev 1/2001

ORIGINAL

			For 1 _ State	State of Ma	aryland	-	rtment of Hertificate of D		Mental	Hygien	ne	00515
			Registrar 1. Decedent's Name (First, Middle, La	ast)		Cer	uncate of L	Jeann —	2. Date	Reg. N	102UU1	3. Time of Death
	Physicia		Shelley P. Bu	,					Montl		Pay Year	1940 M
1	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town, or	Location of Dea			1c. County of Dea	
_	ļ ^a		10308 Conover D					Spring			Montgom	
	Funeral		5. Social Security Number 6. S 577-76-3811	Sex 7. Ag 1 □ M 2 ☐ F	ge (In yrs. la 50	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		of Birth 1 Day, Yes	E Co	thplace (State or Foreign ountry)
b	Director		Usual Residence of Decedent		30				10 0		<u> </u>	C
	ryland how	_	10a. State 10b. County		10c. City	, Town or Lo						10d. Inside City Limits
	ne Ma 8a-f s ptified	Director	MD Montgom	ery		Silve	r Spring					1 □Yes 2 No
	a or 2	Dir	10e. Street and Number				10f. Zip Code 20902				Citizen of What Co	
	heath ms 23 must	Funeral	10308 Conover Dr.	12. Was Decedent		3. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin?	(Specify Yes		ted Stat	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			f Yes, specify Cubai I□Yes 2 No	Specify:	èrto Rican, et	c.)	Specify: B1	
ה ה	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	ļ	16a. Deced	lent's Usual Occupa	ition urina most of w	orkina	16b.	Kind of Business	/Industry
Z	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L Educa	kind of work done d OO NOT use retired) tion Con	sultant			Educatio	n
7	filed v Hygie other 1	S	17. Father's Name (First, Middle, Last			Baaca		18. Mother's N				
yland	ould be Mental narked c	To Be	Vernon F. Green			T			rta Ne			
S	nd 2 sh alth and 27 is n r traun		19a. Informant's Name/Relationship (Robert Burke / Hu				g Address <i>(Street a</i> 8Conover:				,	,,
<u>5</u>	ges 1 a It of Hea If item or othe		20a. Method of Disposition 1 □ Burial 2 Ū Cremation 3 □	Removal from State	20b. Pl	1	sition (Name of natory or other place		Date		Location - City or	
Daithinor	urtmen urtmen urtant: Injury		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Euneral Service Lice	• •	Che		ke Cremat . Name and Addres				tsville	
Ö	Deperment of the concession of		21. digitative of the Elec		myrs	- 1		*			Spring M Vice 933	Gist Ave.
ĕ			23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that cause y one cause on each l	d the death ine.							Approximate Interval Between
	Physician /Medical	6	Immediate Cause (Final disease or condition resulting in death)	a. Metasi	tatic	Breas	t Cancer					Onset and Death
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134	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):						
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0/00,	death certificate be executed e attending physician and of for use as the burial-transit	dical	•	⊾d				_				
Š X O	ding p	/Mec	IF FEMALE:	23c. If yes, outcome	nf nrennal	nev						
	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 [Ectopic pregnancy Other (specify)			_	23d. Date of de Month	Day Year
Z,	s that med b	by Pr	Part II. Other significant conditions	contributing to death b	out not resu	Iting in the ur	nderlying cause give	n in Part I.	23e.	Did tobacc	o use contribute t	o the cause of death?
coras,	equire en sig ould b								_	1 Tes	2 ™ No 3□P	robably 4 Unknown
ב ב	The lar ate has page 2	Completed							24a.	Was an autopsy performed Yes 2	? prior to death?	utopsy findings available completion of cause of s 2 □ No
N 1 2	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospitali				26. Place of D	eath (Check	only one)		
5	Phys r this ral dir	- To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatien 28b. Time of		4 LI Nursing			6 □Other (Spe	ecify)
VISIOII	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Da		Injury	Work	res 2∐No	200. Des	onde now in	ijary occurred	
ZIVIS	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	Zoe. Flace of III	jury - At hor tc. (Specify	me, farm, str	eet, factory, office	1,0		tion (Street or Town, St		ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C		thysician: To the best iminer: On the basis of and manner st	of examinat							
	To the within To the Compl	Me	29b. Signature and title of certifier				29c. License	number		29d. I	Date signed (Mon	th, Day, Year)
	. ~		Paulbanner	MD			MD06	0335			08-29-200)7
7	5		30. Name and address of person who Paul Bannen	completed cause of			Print) Dr. #327	Olnev	MD 20	0832		
Ì	Sta Registr		24 Data filed (Month Day Vocal-:	2007 32. R	trar's Signat	ritt i	11321	Jiney	, 21			
	negisti	uı										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTP://#20b.c.perFH.QS/1.9/21/07.WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Year **Physician** М 2, 2007 4c. County of Peath /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner omewood Birthplace (State or Foreign Country) Age (In yrs. last bit Social Security Number **Funeral** Months Min. Days Hours 1 X M 2 □ F 83 512 Director April 4 North Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours arrended and 2 should be filed within 72 hours arrended and Mental Hygiene.

The file of the 1 XYes 2 No Director mor a10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 40 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Institute of Notre Dame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ (Wife) 19b. Mailing Address (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. otton 10 mont altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Balto. MD King Memorial Fark 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 500 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Linkys Av Rus Enter the dischse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 shock or heart fail Immediate Cause (Final disease or condition resulting in death) **Physician** CANCE ar yngeq /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 2 No 1∐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0062638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 W. Mount Royal Ave. Balto, md. 2121 onathan Ri (Month, Day, Year) State 14 SEP 2007 Registrar

State Registrar

Shakunmala Gupta, 31. Date filed (Month, Day, Year)

SEP 1 4 2007

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, 9650 Santiago Road, Suite 110, Columbia, Maryland 21045

To the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00053150

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Registrar Registrar State of Maryland / Department of Health and Mental Hygiene

1- State Registrar Regist 29518 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 01:15 AM trances raid 4 Z007 /Medical 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manland saltimore 0+ If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sel Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Yrs Director May 6, 86 Maryland 213-18-961<u>5</u> 1921 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show "natural", or Items 23a or 28a-f sh edical Examiner must be notified 1 ☐ Yes 2 No Directo Havre de Grace Maryland Harford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a anny Injury or other traumatic event, the Medical Eventual once. 3828 Rock Run Road 21078 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Irene Carr James Earl Worthington ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Worthington/Brother 4420 Webster-Lapidum Rd., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-27-07 Rock Run Cemetery Havre de Grace, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rebra /Medical Due to (or as a consequence of): Examiner Orebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ON APPROVED BY MEDICAL EXAMINER law requires that the death certificate be executed Hypertension burial-tran Due to (or as a consequence of): attending physician for use as the buria CERTIFICAT Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed' 2 1100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

P.O. Box 68760, Division or Vital Records,

funeral director, this After t death.

Certification: To within 24 hours are death To the Funeral Director completely filled in by the Hospital

State Registrar

Maulocci 31. Date filed (Month, Day, Year

29b. Signature and title of certifier

1 Watural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier (Check only one)

5 Pending investigation

6 Could not be determined



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 11, 2007 11:55 AM James E. Crickey, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery General Hospital Montgomery Olney If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Jan. 27, 1928 5. Social Security Number 6. Sex Days Months 1**X** M 2□ F Pennsylvania 79 180-20-7725 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 15120 Westbury Road United States 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No 1945— If Yes, Give Year or Dates: 1968 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E. Crickey, Sr. Vivian Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7241 Wapello Drive, Derwood, Maryland 20855 Jacquelyn M. McNulty/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 1 N Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery: 4 ☐ Donation 5 ☐ Other (Specify) 18, 2007 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service License Millian M01173 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pach line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMONGRY 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No f Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

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Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified at

than ,

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Iry or other traumatic event, the M

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau
once.

within 72 hours after death with the

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

and burial-tran attending physician for use as the buria ed by the signed by a has

certificate this

To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

Completed Be ဥ Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number

#101

29d. Date signed (Month, Day, Year)

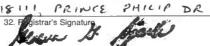
20832

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOTAMEDI 31. Date filed (Month, Day, Year)

SEP 1



State

Registrar

			For State Registrar	State of Ma	-	epartment of F Certificate of I		lental Hyg	giene Reg. N2 N N	7 29520
۲	Physici	an	1. Decedent's Name (First, Middle, Las	nna Car	ter			2. Date of Dea Month	ath Day Y	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death	Septem	ber 11 2	007 8:30p M
Ħ.	Lxamii		Carroll Hospice D			Westmin			Carro	
	Funeral Director		5. Social Security Number 6. Sr 215-28-7354 1	9X 7. Age 7. Age 75	(In yrs. last birtho Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 1	7 1000 -	Birthplace (State or Foreign Country)
4	land ow t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
	e Mary ia-f sho tified a	ctor	MD Carroll		Sykesvi	ille				1 ☐ Yes 2☐ No
	with the	Dire	10e. Street and Number 7504 Patapsco Drí	***		10f. Zip Code			10g. Citizen of Wha	at Country?
	death	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	21784 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No	USA 14. Race -	American Indian, White, etc.
20	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	riiodii, etc./	Specify:	white
2-002B	72 hou 'natura dical E	eted	15. Decedent's Ed (Specify only highest gra	ucation	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	ation during most of work	ing 1	16b. Kind of Busin	ness/Industry
717	I within jiene. r than ' the Me	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)	ife. DO NOT use retired Omponent fa	_		Westingho	ouse Corp.
alla	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be C	17. Father's Name (First, Middle, Last) Clifford Belt		<u> </u>		18. Mother's Name Katarina		Maiden Surname)	
al	2 shoul and M is marl aumatl	Ě	19a. Informant's Name/Relationship (7	• •		Mailing Address (Street				
ຂ ທີ	1 and Health Iem 27 other tr		Carol Carter (dau	ighter)		75 Swallow isposition (Name of crematory or other place		sville,	MD 21784 20c. Location - Cit	
	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specif</i> y			ield Cemet	ery 9-15-		Sykesvill	
סמור	permit. Departi Import any inj		21. Signature of Funeral Service Licen	Herbert		22. Name and Addre P.O. Box 1	ss of Facility Hai 95 Sykesv	ght Fun ille, M	ieral Home ID 21784	e & Chapel
	Physician /Medical Examiner		23a. Part1. Enter the disease, or composition of the control of th	a. Uterir		unocant		or respiratory a	rrest,	Approximate Interval Between Onset and Death
,00,0	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of)					
.O. DOX 00	the death certificate be executed y the attending physician and ached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _	1		23d. Date of Month	
ביים	quires that n signed t	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in th	ne underlying cause giv	en in Part I.	23e. Did to		ute to the cause of death? ☐ Probably 4 ☐ Unknown
מו חבכטו	n: The law red ficate has bee ir, page 2 shou	Completed							osy prio ormed? dea 2 No 1 L	re autopsy findings available or to completion of cause of ath?
IN IO HOISIN	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours affect death. Within 24 hours affect death. To the Funeral Theotor. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	25. Was case referred to medical examiner? 1		Year) 28b. Tim	ne of 28c. Injur	y at k? Yes 2 \(\backsquare\) No	me 5 ☐ Resid 28d. Describe I	dence 6 Other how injury occurred	(Specify) HO'2 LL
4	Hospital 24 hours Funeral stely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of niner: On the basis of e and manner state	examination and/	death occurred at the til or investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	To the within To the compli	Me	29b. Signature and title of certifier Marshell			29c. Licens D/7	e number 873		29d. Date signed (1	
0	71		30 Name and address of person who a Mans heal A Land SEP1 4	completed cause of dea	th (Item 23a) (Ty 569 N	onth Cha	irles St	Tows	son, MD	er 12,2007 21204
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP1 4	2007 32. Regular	's Signature	fort				•

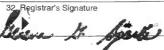
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 Charles F. Dirlam September 10, 11:30 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 □ F Director 210-22-3095 30, 1929 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9217 Falls Chapel Way Funeral 20854 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1950-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. Black, White, etc. 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White \$ 1952 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. To smarked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Administrative Law Judge 5+ U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis J. Dirlam ပ္ Helen Monahan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any Injury or other traurr once. Catherine E. Dirlam/Wife 9217 Falls Chapel Way, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery: 14, 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licenta 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.
300 W. Montgomery Avenue, Rockville, Maryland 20850 William M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Malignant Arrythmia Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Ulssase or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed use as the burial-transi and Due to (or as a consequence of) Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ξ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed? Yes 2 \ No certificate Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 💢 Natural 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland Yogin Patel, M.D.

State Registrar

31. Date filed (Month, Day, Year)



ORIGINAL

29523 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Smith Daly Joanne Joanno Smith Daley 12:43a^M Sept 8,2007 /Medical 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 213 Upton St. 4b. City, Town, or Location of Death Rockville Examiner 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1 M 2 F 217-44-8231 Washington, DO Director 59 04/02/1948 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at Yes 2 No Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death y 20850 Funeral U.S.A. 213 Upton St 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏌 No 3 Widowed 4 Divorced Specify: SpecifyWhite þ Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) $4 \pm$ Vice President A.C.L.I.other permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 Is marked other any Injury or other treumatic event, pubg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Leo W. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa White/Sister 15 Newlands St. Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Anatomy Gifts Reg. 09-8-2007 Hanover, MD 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Licenses Konald 108 W. North Ave., Baltimore, MD 21201 23a. Part1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Gastric Cancer /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter und fying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien a hed for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 9 es been signal 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an hes autopsy performed After this certificete 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 ☐ Yes 2 V No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hours after To the Hospital c within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one)

State

31. Date filed (Month, Day, Year)

Dr. Manish Agrawal

29b. Signature and title of certifier

- 9707 Medical Center DR., Rockville, MD. 20850 32. Regissar's Signature

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

62234

29d. Date signed (Month, Day, Year)

SEPTEMBER 12,2007

				artment of Health and Mental <i>rtificate of Death</i>	Hygiene 2007	29524
7	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date Mon Se		
4	/Medic Examin		Michael Evans 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
			1119 Berrymans Lane	Reisterstown	Balti	more
\$	Funeral Director		5. Social Security Number 218-64-5069 6. Sex 7. Age (In yrs. last birthday) 52 Yrs.	Months Days Hours Min. (Mor	of Birth 9. Binth, Day, Year) 9. Binth, Day, Year)	rthplace (State or Foreign Country) NJ
	land ow It		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation		10d. Inside City Limits
	a-f sh	ctor	MD Baltimore Reisters	stown		1 □ Yes 2 No
	h with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 1119 Berrymans Lane	10f. Zip Code 21136	10g. Citizen of What C	country?
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 Never Married 2 N Married 1 N Yes 2 No 19/4−	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2 ☑ No Specify:	or No- tc.) 14. Race - Arr Black, Wh Specify: wh	ite, etc.
9	72 hou natura lical E	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16b. Kind of Busines	s/Industry
2	rithin 7 ne. han "r e Med	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	Signature	Support Serv.
2	iled w Hygiel ther tl nt, th		17. Father's Name (<i>First, Middle, Last</i>)	ntions manager 18. Mother's Name (First, N	Middle Maiden Surname)	
ano	should be tand Mental Is marked of	To Be	Edward Evans Sr.	Ella Mae Par		
Maryland 21215-0036	and 2 shou ealth and M n 27 is mar er traumati			ng Address <i>(Street and Number or Rural Route</i> Berrymans Ln., Reiste		
Baltimore,	0			osition (Name of Date matory or other place) on Memorial 9-14-07	20c. Location - City of Marriotsvi	
Baltir	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility Haight O. Box 195 Sykesville		& Chapel
		-	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	-		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. OBSTRUCT VE Due to (or as a consequence of):	SLEED APHEA		Onset and Death
1	Examiner	_	Sequentially list conditions, b. CORONARY P	ARTERY DISEASE		10 YEARS
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•		20,,00
oʻ	ificate be executed g physician and as the burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			20 years
68760,	ate be	edical	d	·		
O. Box 6	attending for use	Physician/Me		⊒Ectopic pregnancy ☐ Other (specify)	23d. Date of d	elivery Day Year
<u> </u>	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e	. Did tobacco use contribute	to the cause of death?
rds	aquires en sign	ed by	DIABETES MELLITUS		1 Yes 2 No 3 €	robably 4 Unknown
Vital Records,	siclan: The law re certificate has be irector, page 2 sho	Completed			. Was an autopsy performed? Yes 2 No 1 □ Yes	
ıta	iysiclan: lis certifica director, I	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		3 12 10
0	this ald	٩	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		Residence 6 Other (Sp	ecify)
	Ing Ine	ţion:	27. Manner of Death 28a. Date of Injury 1 ID Natural 5 □ Pending 2 □ Accident investigation 28b. Time or Injury Injury	f 28c. Injury at 28d. Des Work? M 1 ☐ Yes 2 ☐ No	cribe how injury occurred	
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Loca	ation <i>(Street and Number or I</i> or Town, State)	Rural Route Number,
	e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatled the properties of examination and/or in and manner stated.	h occurred at the time, date and place, and due vestigation, in my opinion, death occurred at the	to the cause(s) and manner a time, date and place, and di	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
}			Legetyladieter	D50913	09-11-	2007-
2			30. Name and address of person who completed cause of death (Herri 23a) (Type, IEIGHTON FORRESTER 7506 HA) 31. Date filed (Month, Day, Year) SEP 1 4 2007	Print) NOVER PROY, SUITE 20	Y GREENBE	2007- LT, MARYLAND 0770
			31. Date filed (Month, Day, Year) 32. Registrar's Signature			

The law requires that the death certificate be executed ig physician and as the burial-tran Division or Vital Records, P.O. Box 68760. attending plant signed by the a has e 2 certificate ha or Attending Physician: funeral After s after death.

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permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any Injury or other trau once.

Physician /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Medical Certification: 5 ☐ Pending investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and Itle of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE L BOUTZALE, M.D. 7601 OSLER DRIVE

32. Registrar's Signature

SEP14

31. Date filed (Month, Day, Year)



State Registrar D58944

29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** DNITRA FORI TENTEMBER 11, 2007 /Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NV, 25) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMONE ADE CINTER NONTHWEST MITAL 9. Birthplace (State or Foreign Gountry)
Mary and 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 214-80-0680 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location show r 28a-f show notified at 1 XYes 2 □ No Funeral Director more 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? ms 23a or ; th and Mental Hygiene.
7 Is marked other than "natural", or Items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 ☐ Widowed 4 X Divorced 3100 Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) omas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) (4 rand father) Herlin Health em 27 I Davenport Injury or other Saltimore, Department of Heal Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/2007 Voodlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Rame and Address of Facility Joseph L. Russ Fun 2222 W. North Ave. Funeral H tve. Balto. 23a. Part/ Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia. Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner AS45 TOLIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nuantiativ tist panditions Examiner The law requires that the death certificate be executed END STACE burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No STATUS PEST BILATORA The Sci Sci 1 Yes 2 (26. Place of Death (Check only one) 2 -No 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | No 1 Hnpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pleating 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

29b. Signature and title of certifier

OPLANDO 31. Date filed (Month, Day,

30. Name and address of person who comb

SEP

Year)

14

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CONTRA

29c. License number

29d. Date signed (Month, Day, Year)

PANDALISTON MANYLA

			_ FOI	-	Department of H		ental Hygiene	9	
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L		Reg. No.	2007	29527
Ш	Physici		T. (T. A. A.)	ニナナフ	T.C. 16		Month Da	y Year	3. Time of Death
-	/Medio		4a. Facility Name (If not institution, give street and n	umber)	4b. Gity, Town, or	Location of Death	40	County of Death	3,77
1.000			Mever Medici	Al Cent	Y Bul	(IIMU)	K 1	SALTI	MUNE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Year,	Coun	
	Director		151-16-6764		113.		09/29/1923	B New	Jersey
	how how		10a. State 10b. County	10c. City, Towr	n or Location			1	0d. Inside City Limits
	Ba-f s	Directo	New Jersey Cape May	Middle	Township/ C	ape May C			1 ☑ Yes 2 ☐ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		10e Street and Number 230 Indian Trail Road		10f. Zip Code	08210	10g. Ci	tizen of What Cour	
	ems 2	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S.	13. Was Decedent of His If Yes, specify Cuba	spanic Origin? (Spec	cify Yes or No-	14. Race - Americ Black, White,	
36	ırs afte ıl", or it 'xamin	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or	-orces? 2 2 No aive Dates:	1 ☐ Yes 2 No	Specify:			hite
21215-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed		Decedent's Usual Occupa	ation Juring most of workin	16b. k	(ind of Business/Ind	dustry
121	within ane. Ithan "	mple		(1-40r 5+)	(Give kind of work done d life. DO NOT use retired, etail Sales (R	etail Pro	duce Market
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Maryland	2 should and Men Is marker aumatic		19a. Informant's Name/Relationship (Type. Print)		. Mailing Address (Street a				*
_	1 and Health em 27 ther tr		Joanna May Fitzick - Da 20a. Method of Disposition		2526 Guilford		Baltimore	ocation - City or To	
nor	Pages nent of I ant: If Its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of ry, crematory or other place Creek Methodi			•	
altimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee) preen c	22. Name and Addres	The second secon	5305 H	arford Ro	ad
<u>m</u> —	o a l De		Chales of Mines	<i>f</i>	Leonard J.	Ruck, Inc	Baltim	ore, MD 2	21214
8.		d .	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do reach line.				-	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	UMOCOC		NEUM			14/dA4
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	ecute and -trans	Examiner	that initiated events c.	o (or as a consequence o					
8760,	cate be executed physician and the burial-transit	dical E	L.		51).				
9	tificate g phy as the	ledic	a.						
Box	leath certific attending p	an/IV	23b. Was decedent pregnant	utcome pf pregnancy birth 2 Tetal death	3□Ectopic pregnancy			23d. Date of delive	,
0	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me		gnant at time of death	5 ☐ Other (specify)			Month	Day Year
о. С	s that the ned by detact	by Ph	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
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Records,	e law ru has be je 2 sho	Completed					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
_							performed? 1□ Yes 2□N	death?	2 No
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20.	ding Phys L After this funeral di	H- 1	27. Manner of Death 28a. Date	e of Injury 28b. 1	Time of 28c. Injury		8d. Describe how inju		<i>y)</i>
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Division or		Certification:	determined 20e. Flac	ce of injury - At home, fading, etc. (Specify)	rm, street, factory, office	28	Bf. Location (Street a City or Town, Stat		il Route Number,
	Hospital or 24 hours afte Funeral Dir etely filled in t		29a. Certifier 1 CertifyIng Physician: To the						
	To the Hos within 24 ha To the Fun completely	ledical		basis of examination an unner stated.			ed at the time, date ar	nd place, and due to	the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier		29c. License	number	29d. Da	ate signed (Month,	Day, Year)
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1	1		30. Name and address of person who completed car	use or death (Item 23a) (Type, Print)	- Biol.	TIMI	NE N	1 0 2 120x
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		1	1 - For State of Maryland / Department of State of Maryland / Department / De	artment of Health and M rtificate of Death	Reg	ne . No. 2007	29528				
ya.	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) THEL MA FLOY	D	2. Date of Death Month O 8	Day 2007	1:00 PM M				
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
	Funeral		Haven Nursing Home 5. Social Security Number 6. Sex 1 □ M 2 ▼ F 91 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan 1, 19	rear) Cou	nplace (State or Foreign intry) yland				
1.8	Director	Funeral Director	Usual Residence of Decedent		Dan 1, 1,	710 1101	10d. Inside City Limits				
	ryland how Lat		10a. State 10b. County 10c. City, Town or Lo				1 Yes 2 No				
	e Ma Ba-f s			altimore	100	g. Citizen of What Cou					
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show dother than "matural" or items 24a or 28a-f show event, the Medical Examiner must be notified at	Dir	10e. Street and Number	10f. Zip Code	105		,				
		eral	3939 Penhurst Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specity Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Amer					
21215-0036		ğ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specity Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White	lack				
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d 2	filed within Hygiene. Ather than Sther than		17. Father's Name (First, Middle, Last)	(First, Middle, Maiden Surname)							
lan		To Be	Richard Frederick Dinkins	Ada K							
Maryland	d 2 in the an transfer transfe		19a. Informant's Name/Relationship (Type. Print) Andrea Rossgreen/daughter 19b. Mail	ing Address (Street and Number or Rui S. Alandele Los A	ngeles, (City or Town, State, 2 CA 90030	Zip Code)				
Baltimore,	of ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify)	ematory or other place)		Oc. Location - City or					
Balti	permit. Pages Department of Important: If it any injury or once.		Sign the liner Service Licensee Street State Anatomy aboard 655 W. Baltimore Street Baltimore, MD 21201								
	sician: The law requires that the death certificate be executed a personned may be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshow, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	y Artury 2	40		Approximate Interval Between Onset and Death				
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	Hospital 24 hours a Funeral	Medical Ce	29a. Certifier (Check only one) 1 SCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the comple	Mec	29b. Signature and title of certifier PHYSICIAN	29c. License number \$\mathcal{D}\$ 5754		9d. Date signed (Mor					
•			30. Name and address of person who completed cause of death (Item 23a) (Type 1-5ANDHU mp 1940 W. BA								
90	S Regis	tate trar	31. Date filed (Month; Day, Year) 32. Registrar's Signature	hoard o							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29529 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 11:39 PM Physician September 09, 2007 Rita S. Francomano /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) 10-22-1940 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Min. Hours 1□ M 2♥ F 326-32-7491 Illinois Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State Item 27 is marked other then "natural", or Iteme 23a or 28e-f show other traumatic event, the Madical Examinat must be notified at 1 ☐ Yes 2 ☑ No Towson Baltimore Funeral Director MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21204 8208 Yarborough Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 and 2 should be filed within 72 hours after of the the and Mental Hygiene. Heatth and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Etementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Block Emmitt Stacy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8208 Yarborough Road, Towson, MD 21204 John R. Francomano/Husband Health tem 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Mt. OTivet Cemetery Kewanee, Illinois ō = 5 9/15/07 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury of once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Service Licens e Ruck Towson Funeral Home, Inc. Towson, MD 21204 Towson, MD 1050 York Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Lac avre disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and the burial-transit Examin Hospitel or Attending Physician: The law requires that the death certificate be executed arrhy Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ZNo 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No After this funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No death. neral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide within 24 hours after d To the Funeral Direct 4 | Homicide ***Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartiflar Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOD 63180 September 10, 2007 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) St. Boltmore MO 21204 6701 Chur

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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N.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5113 PM 2007 В. Fanshaw September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultmore Baltimore ot If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 X F 75 MD 216-28-6760 29 Dec. **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Glyndon Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21071 death v Funeral 204 Central Ave. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Maryland 21215-0036 'natural', or Specify 2 3 Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore FederalBank Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ew Lois Constantine William T. Bucher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Glyndon Ave., Glyndon, MD Thomas P. Fanshaw Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery 9/13/07 Pikesville, MD 21. Signature of Far All Salvice 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 years **Physician** /Medical Due to (or as a consequence of): Examiner Carcinama Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Funeral Director: stely filled in by the hours within 2

Knew

State Registrar

Medical

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SEP1 4

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) September 10,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Mighrajam Chandra

and manner stated

32. Signature

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

death 1

Pages 1 and 2 should be filed within 72 hours after

3altimore, Maryland 21215-0036

physician and s the burial-trans attending p for use as signed by the a certificate this After t n 24 hours after coccide Funeral Director: Af

within 2. To the I

MONESES State Registrar

3 ☐ Suicide 4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Medical

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and manner stated

29c. License number

1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

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21061 6 (en Pornie MA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined

		1	For State Registrar	State of Ma	•	oartment of H e <i>rtificate of L</i>			giene Reg. No. 1	2007	29532	
	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of Death	
	Physician Zorah G. Gingrich								ber 10, 2007 10:00PM M			
Exam			a. Facility Name (If not institution, give	4b. City, Town, or Location of Death Cockeysville			4c. C	County of Death				
			Maryland Masonic Social Security Number 6. Securit		(In yrs. last birthda		SVIIIE If Under 24 Hrs.	8. Date of Birt	h	Balti:		
Funera Directo	-			□M 21/XF	97 Yrs	Months Davs	Hours Min.	May 5,	y, Yea <i>r)</i>	Cou	place (State or Foreign ntry) MD	
and and t		- H	Usual Residence of Decedent Oa. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits	
Maryl -f sho iled a	3	ğ	MD Balti	more	Re	isterstown					1 □ Yes A∏ No	
n the r 28a	9	Ulrector	Oe. Street and Number	LINO I O		10f. Zip Code			10g. Citize	en of What Cou	intry?	
th wit 23a o ast be	3	<u>a</u>	100 Neel Ave.			211				USA	Ladia -	
er dea tems ter mu		runeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No o Rican, etc.)	1.	 Race - Ameri Black, White 		
hours afte		D.	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2X\n If Yes, Give Year or Dates:	10	1 ☐ Yes 2X No	Specify:			Specify: Wh	nite	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Inmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	3	ed .	15. Decedent's Ec	lucation de completed)	16a. De	cedent's Usual Occupive kind of work done	ation during most of work	king	16b. Kin	d of Business/Ir	ndustry	
within ane.		Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Manager	<i>a)</i>			Retail		
filed Hygie	3		17. Father's Name (First, Middle, Last,)		Hanager	18. Mother's Nam	ne (First, Middle	, Maiden S	Surname)		
ild be fill lental H ked oth	3	0 26	Thomas D. Gooch	ı			Blanc	he Mahai	nna			
shou and N s mar		1	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Z	ip Code)	
and 2 ealth n 27 i			Joanne G. Raver	Daughter		Neel Ave.		stown,		21136 cation - City or T	Town State	
ges 1 tof He or oth			20a. Method of Disposition 1 [X] Buna! 2 ☐ Cremation 3 ☐	Removal from State	I	sposition (Name of crematory or other pla	4 .					
t. Pag rtmen rtant:		-	4 ☐ Donation 5 ☐ Other (Specif	(y)	Evergree	en Memorial 22. Name and Addre		4/07		istoret	own Road	
permit. Pages Department of Important: If it	once		21. Signature of Juliera Service Lice	- 2		Eline Fun				town, M		
100		1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between								Approximate Interval Between	
Physicia	ın		Immediate Cause (Final disease or condition	GVI	+RIA.		1 cer				Onset and Death	
/Medica	-		resulting in death)	Due to (or as	a consequence of)	-0						
Examine		_	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of)							
nted Insit	\neg	Examiner	if any, leading to immediate cause. Enter Underthing Cause (Disease or injury that initiated events c									
icate be executed physician and the burial-transit		Exa	resulting in death) Last									
icate be ex physician as the burial		dical		d								
entific ling p		Med	IF FEMALE:	23c. If yes, outcome	nf pregnancy		2.00			23d. Date of deli	ivery	
death certifi e attending		Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у			Month	Day Year	
the cy th		ysi	1 ☐ Yes 2 M No 9 ☐ Unknown	9□Unknown								
s that med b e deta		by Pi	Takin Ottor Symmouth Control of the									
w requires to been signed should be		ed				<u>. </u>		1	Yes 2	No 3□Pr	obably 4 Unknown	
The law requires that the has been signed by age 2 should be detailed.		Completed						24a. Wa	s an opsy formed?	24b. Were au prior to death?	utopsy findings available completion of cause of	
		5						1 Yes	2X(No	1 ☐ Yes	2□No	
VICAL DECOTOS, sician: The law requires t certificate has been signe rector, page 2 should be or	1	Be	25. Was case referred to medical examiner?	Hospital:	ant ACTER/Outs	otiont 2000 Ot	26. Place of De			G □Other (See	oifu)	
Phys er this eral dii		2	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
nding H. H. Tafte e fune		tior	1X Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No									
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	.	Certification:	3 Suicide 6 Could not l 4 Homicide determined	Zoe, Flace of in	jury - At home, fam tc. <i>(Specify)</i>	, street, factory, office		28f. Location City or Te	(Street an own, State	nd Number or Ru e)	ural Route Number,	
oital o urs aft eral Di												
To the Hospital or within 24 hours afte to the Funeral Dir		Medical	29a. Certifier (Check only one) Certifying P 2 Medical Example	aminer: On the basis and manner s	of examination and	or investigation, in my	opinion, death occ	curred at the time	e, date and	d place, and due	e to the cause(s)	
To the within To the Comple		Me	29b. Signature and title of certifier	, 0			ise number		29d. Dat	te signed (Mont	th, Day, Year)	
-5	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. BOWIE, M.D. 6701 N. CHARLES ST. #490Z, BALTIMORE, I 11. Date filed (Month, Day, Year) SEP 1 4 2007 32. Regulars's Signature						111/2	007			
4			30. Name and address of person who	completed cause of	death (Item 23a) (T	Print)	ST. #49n	Z. BAIT	TMOD	E. MARU	(LAND 21204	
(Sta	te	31. Date filed (Month, Day, Year)	32. Reg	trar's Signature	CHUVES !	-1 1/0	<u></u>	,	~1.1107	-10 21201	
Reg			SEP1 4	2007	en &	Sperke						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 1255 SEPTEMBER WILLIAM 2007 HARVEY 11. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE RANDAUSTONN HOSPITAL MORTHWEST If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Sex 1 M 2 □ F Months Days Hours Yrs. 215-24-0967 79 11/3/1927 Maryland Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c, City, Town or Location 10b. County r 28a-f show notified at 10a. State 1 ☐ Yes 2 ☐ No MD Director Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 3 Pantley Court, Apt. H 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Mail Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Harvey, Sr. Reiva Dowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sis. 1 Wickham Court, Reisterstown, MD 21136 Elizabeth H. Hanixman / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 9/14/2007 Glen Burnie, MD Glen Haven Ceme. 4 Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. . Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Dreunones /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burlal-tran Due to (or as a consequence of): physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for 1 Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig , page 2 should b Completed 24a. Was an autopsy performed? Yes 22 No 1⊟ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ∏Yes 2 ∏No n 24 hours after death.

Per Funeral Director: A sletely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059736 7 7 pehr mo

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Baltimore, Maryland 21215-0036

O. Box 68760,

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Division or Vital Records,

State Registrar

DHMH 17 Rev 1/2001

WORTHWEST HOSPITME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WATJOR

2007

31. Date filed (Month, Day, Year) SEP 14. 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 29534 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SEPT **Physician** 4-30 PM 2007 HOWARD 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** RSING HOME 7. Age (Infyrs. last birthday) olumbia toward LORIEN 8. Date of Birth (Month, Day, Year)

0 2 - 09-1926 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** Months Days Hours Min 1 ☐ M 2 🗶 F 216-24-8229 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f ehow other traumatic event, the Madical Examiner count be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21215 or items 23a by Funerai filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3/ack 3 Widowed 4 ☐ Divorced "netural", Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) other then Hygiene. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental sut: if item 27 is marked o 10WNes 2 Torence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rances 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of importent: If it eny injury or o Purial 2 ☐ Cremation 3 ☐ Removal from State Cem Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address, of Facility Chatman - Harris Fyneral h 5240 Rejsters town Rd 21. Signature of Funeral Service Licensee 102/2/5 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS a CEREBROVAS CULAR ACCIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Monuto Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner this certificete has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. \prec resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 22 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 20 No Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred hours after death. unerel Director; After or Attending 1 Natural Injury 5 Pending 1 🗀 Yes 2 🗆 No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD 00053150

Registrar DHMH 17 Rev 1/200

State

9650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shakun mal 31. Date filed (Month, Day, Year) SEP 1 4 2007

Gup de 32 Registrar's Signature

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			1 - For State Registrar	State of M	laryland / Dep Ce	artmen ertificate	t of He	alth an		giene 2007	29535	
н	Physici	ian	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death									
	/Medi		Thedora Verdene			1 0				30, 2007	8:20 PM M	
	Examir	ner	4a. Facility Name (If not institution, given 6711 Park Heigh:		7		timor	ocation of E	eath	4c. County of De	ath	
	Funeral	_	5. Social Security Number 6. S		ge (In yrs. last birthda)) If Under	1 Year	If Under 24		h . 9. B	irthplace (State or Foreign Country)	
	Director	Н	213-32-2243	□M 257 F	73 Yrs.	Months	Days	Hours 1	Min. (Month, Day Dec 21		rginia	
	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Obeperment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show sny injury or other traumatic event, the Medical Extendent must be notified at ance.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits	
		ō	MD		Balti						1 Yes 2 No	
		rect	10e. Street and Number		Darei	10f. Zip	Code			10g. Citizen of What		
		<u></u>	6711 Park Heights Avenue 21215							USA	,	
		To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?				. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.	
98			1 Never Married 2 Married	No	No 1 ☐ Yes 25 No Specity:			dono modin, dio.,				
21215-0036	hours tural		3 Ø Widowed 4 □ Divorced	Year or Dates:		edent's Usua		00		Specify: black 16b. Kind of Business/Industry		
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212	should be filed with and Mental Hygiene. • marked other ther umatic event, It e. M.		Elementary/Se <i>co</i> ndary (0-12)	College (1-4or 4		unselc	r			community	college	
Pu			17. Father's Name (First, Middle, Last)				1:	8. Mother's	Name (First, Middle,			
yla			Irvin Wilson Car	ter				Rache	l Julia Ja	ackson		
Maryland	2 sh and ie m	0	19a. Informant's Name/Relationship (Shelley Hawkins/							r, City or Town, State	i a a si a	
	1 and Health em 27 ther ti		20a. Method of Disposition		20b. Place of Disp			Lou St	reet Balt:	20c. Location - City	21216	
Baltimore,	permit. Pages 'Depertment of H important: If ite eny injury or of		1 Burial 2 Cremation 3		cometens co			1	build	Zoc. Location - Oily (or rown, state	
Ħ			4 Donation 5 Other (Specify 21. Signatur 1 Funeral Arrice Licen		1	22. Name an	d Address	of Facility				
Ã			21. Signatur Funeral Invice Licensee Street State Anatomy Board 655 W. Baltimore Stree									
			25a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between									
	Physician		Immediate Cause (Final disease or condition resulting in death) A FIASTATIC GASTRIC CANCER Onset and Death Onset and Death									
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):		211 2	1010	CY 100			
	tath certificate be executed attending physicien and for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
		ulue										
		xan										
68760,		cal										
89		ed										
Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
Э. В		sici							Month			
P.O.	that the de led by the detached	Phy	9 Unknown	natributing to death	but not cogniting in the			in David	220 Did to	bassa usa santributa	to the cause of death?	
of Vital Records,	The law requires that has been signe page 2 should be d	d b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba 1 Yes CONGESTIVE ITBART ROWER 24a. Was an								☐ Probably 4 ☐Unknown	
Sor		Completed by										
Re		m d	WNOTOTIV	1 1	C) N)	WKE	=1		24a. Was autop	sv prior to	autopsy findings available completion of cause of	
ā	ician: Th certificate rector, pag		25. Was case referred to medical	Nomis				C Place of		212No 1□Ye	es 2□No	
>	ysicia is cert direct	To Be	examiner?	Hospital: 1 ☐ Inpat	ient 2 ER/Outpatie	ent 3 DO	Other			ence 6 ⊡Other <i>(Sp</i>	necify)	
	after Ing		27. Manner of eath	28a. Date of Inj	ury 28b. Time		Bc. Injury at Work?			ow injury occurred	oony	
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Division		Ĕ	3 Suicide 6 Could not be determined	treet, factory	eet, factory, office 28f. Location (S City or Tow			itreet and Number or Rural Route Number, n, State)				
	Hospital of the same of the sa											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical	29a. Certifier 1. Cartifying Ph (Check only one) 2 Medical Exam	ysician: To the besi niner: On the basis of and manner s	of examination and/or i	th occurred a nvestigation,	at the time, in my opin	date and paid in death of	lace, and due to the o occurred at the time, o	ause(s) and manner date and place, and d	as stated. ue to the cause(s)	
		Med	29b. Signature and title of certifier								. Date signed (Month, Day, Year)	
	> = 0		DP. LEDAK	is M	0	1	470	936	1 5	FATEMRE	TEMBER 4, 2007	
			30. Name and address of person who	completed cause of	death (Item 23a) (Type	Deirett						
_			Y.CEDAKIS M	0 22	1 ST. PA			SAUT	Mone	MD 21	607	
	Sta		31. Date filed (Month, Day, Year)	32. Regist	trar's Signature	MONEY.	9					
	Registrar SEP 1 3 2007											

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 25-07 7:30 PM Betty Holmes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Towson Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 7, 1945 9. Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min 1 ☐ M 2 🔽 F 62 042-38-6181 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐Yes 2☐ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be USA 21212 4411 Old York Road Funeral unk 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2½ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black <u></u> 3 ☐ Widowed 4 ☐ Divorced Completed unk the Medical unk 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wi frnent of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, the unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manor Care Towson 509 E. Joppa Road Towson, MD 21204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4□Donation 5KOther (Specify) in state 21. Signature of Fundal Service Licensee Ronald Swade. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Large InoPeruble
Due to (ora) a consequence of: Neck Tumor of **Physician** disease or condition resulting in death) /Medical Examiner SChiz Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2№ No 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 SkNo Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cyrus Asadi, 20E. Timen. un rd. # 209 Timen. um, MO 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} 13, 2007 Josephine W. Henderson Sept. 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 9028 Old Harford Road Parkville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 7/28/1933 1 1 M 2 X F 74 Maryland 215-32-0358 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore 1 ☐ Yes XX No Parkville Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number d 2 should be filed within 72 hours after death with th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be ! 9028 01d Harford Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CCBC Catonsville Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Bortle Catherine Frederick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun once, James W. Henderson / Husband 9028 Old Harford Road Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1)XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 9/17/2007 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE Carnac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events at the cause of the cause) Dise to (or as a nonsequence of) Examine the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has t lirector, page 2 s autopsy perform death? 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ∠ ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. Division or Vital Records, P.O.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

Medical

110HAE 31. Date filed (Month, Day,

4 Homicide

29b. Signature and title

29a, Certifier

8109 HARRON

ort who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1xCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Parkville MD

Division or Vital Records, P.O. Box 68760

or Attending Physician: The law requires that the death certificate be executed and -tra physician an s the burial-tr attending p as signed by the a Id be detached f should certificate has birector, page 2 s funeral director this After ours after death. neral Director: A filled in by the fu within 24 hours a

To the Funeral I

completely filled the

28a-f show

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Items 23a

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"natural",

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

29a. Certifier (Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARM, 7610 CARROLL AVE, STE340, TAKOMA PARK, MD 20912

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day, Year) State SEP1 4 Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 7 per flb 9871 9-18-07 vt.
State of Maryland Department of Health and Mental Hygiene Reg. No 2007 29539 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 9:10 PM September Ruth V. Higgins 8 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mardrin House Chesapeake Hospice Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🛚 F 79 228-30-5601 July 20,1928 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Maryland Anne Arundel <u>Pasadena</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8111 Solley Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Line Leader Manufacturering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Thomas</u> Neff <u>Mary V. Mitchell</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Higgins, Sr.- son 8111 Solley Rd., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 NBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Abbev Mem. Gardems 9/14/07 | Auburndale, Florida 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licensee 3111 Mountain Rd., Pasadena. MD 21122 23a. Parti. Enter the disease, or complications that caused the dashock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 211 Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specific Const 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury

Physician /Medical **Examiner** be executed

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed

Be

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Funeral

Director

jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

within 72

d 2 should be filed w h and Mental Hygiel 7 is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev

burial-trar and attending physiclan for use as the buria signed by the a director, funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t After t

Division or Vital Records, P.O. Box 68760

Examine Physician/Medical 2 Completed Be Certification: To filled in by the

Medical

State

Registrar

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Magner of Death 5 ☐ Pending investigation Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

29a. Certifier (Check only one)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30) Name and address of person who completed cause of death (Item 23a) (Type, Print)

iessell k, De 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 2007

gistrar's Signature

To the Hosp within 24 hor To the Fune completely f

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Blondell Johnson 12 9 2007 4:50p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ΝÁ Baltimore Rock Glen N.H. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2□F 239-18-1685 Director 2-22-1919 N.C. 88 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 'natural', or Items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2592 Edmondson Ave. 21223 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced Black Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 h (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Other People Homes 10th grade Domestic 12 should be filed w n and Mental Hygier **is marked other ti** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Wilkes Talmadge Patrick Nola ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2592 Edmondson Ave, Baltimore, Md. Mamie Waugh Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-19-07 Anne Arundel Co., Md. Cedar Hill Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 htt. Enter the disease, or complications that caused the thath. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impudiate Cause (Final disease or condition resulting in death) gasteic Caecinoma **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the attending IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No for Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 I Inknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an page 2 s has certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 TYes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred After t Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled In by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

within 24 the

> State Registrar

Medical

29a. Certifier

(Check only one)

Justin

31. Date filed (Month, Day,

29b. Signature and title of certifier

821 N. Enfact St, Ste 407

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pari,

Year

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

13215

29d. Date signed (Month, Day, Year)

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Baltimace, MS

07-06801 Arnold Jefferson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 29542

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Physician	/	Decedent's Name (First, Middle,Last)					Date of Death		3. Time of Death
ıl Examine	er	Arnola	Jeffers	Sori		5	Month Day September 1,	2007 Year	2356 hrs
	4	4a. Facility Name (if not institution, give street and r			y, Town, or Location			c. County of	Death
		Prince George's Hospital		Ch	everly	•		Prince Ge	eorge's
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	pirthday) If U	Inder 1 Year If Un	nder 24Hrs. 8	. Date of Birth(MI	W/DD/YYYY)	9. Birthplace (State or
Director		578-90-0774 1XM 2 F		Mo	nths Days Hou	ırs Min.	09-27-1	063	Foreign CountrWaSh1ngLO
	L		43	Yrs.		+ -	09-27-1	303	ood washing to
· · · · · · · · · · · · · · · · · · ·		Usual Residence of Decedent 10a. State 10b. County	10c City Tow	vn or Location					10d. Inside City Limits
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Aaryland 28n-f show at once.	٦L	DC	was	shington	-				
th the Maryland 23a or 28a-f sho 10tified at once.	Director	10e. Street and Number		10f.	Zip Code		10g. C	itizen of Wha	at Country?
the a ser	5∣	5748 Blaine Street, N.	F.	10	20011		-33	USA	
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item item	림	A Never Married 2 Married	Forces?	If Yes, sp	ecify Cuban, Mexic	an, Puerto Ric	an, etc.)	White,	, etc.
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Mental H marked c event, t	8	Unknown		N S		<u>Mary H</u>	umphrey		
d Min	-1	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Addr	ress (Street and N	lumber or Rura	al Route Number,	City or Town	n, State, Zip Code)
th and the strength of the str		Carol Stewart/Niece	5	109 III	<u>inois Ave</u>	. NW , Wa	shington	, DC	20011
l and 2 shou Health and I fitem 27 is or traumatic		20a. Method of Disposition		e of Disposition (Name of cemetery,	D	ate 20	c. Location -	City or Town, State
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ysicían		a. Part I. F. I. disease, or complications that	t caused the death. Do	not enter the mo	ide of dying, such a	s cardiac or re	spiratory arrest, s	shock, or hea	Approximate Interval Between Onset and
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ospital or Attending Physicians: The law requires that the death certificate be executed hours after death a shear death. Increal Director: After this certificate has been signed by the attending physician and yfilled in by the funeral director, page 2 should be detached for use as the burial - transit.	Medical Certification: To Be Completed by Physician/Medical Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lower to or as the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lower to or as the cause. So the cause is the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lower to or as the cause (Disease or injury that initiated events resulting in death) Last Lower to or as the cause (Color as the cause of the cause (Color as the cause of the ca	s a consequence of): s a conse	P(Outpatient 3 Bb. Time of Injury e, farm, street, factor investigation, investigation, incomplete in the investigation, incomplete investigation, investigation, investigation, investigation, investig	/19/07 TT rath 3 Ecto Specify) ying cause given in 26.Place of Dea DOA Other 28c. Injury at W 1 Yes 2 ctory, office building Ce tt the time, date and n my opinion, death O.C.M.E.	ath (Check only Nursing I) York? 2/ You be a second of the control	23e. Did tobac 1 Yes 2 24a. Was an autopsy performer 1 Yes 2 y one) Home 5 Res 3d. Describe how unknown 3f. Location (Stree or Town, State 748 Blaine) 1e to the cause(s) 1e time, date and	Month co use contri No 3 24b. V do d No 1 idence 6 injury occurr et and Numbo St. NE and manner place, and d od. Date sign	Death delivery Day Year bute to the cause of death? Probably 4 Unknown Were autopsy findings available rior to completion of cause of leath? Vere autopsy findings available rior to completion of cause of leath? Vere autopsy findings available rior to completion of cause of leath? Vere autopsy findings available rior to completion of cause of leath? Vere autopsy findings available rior to completion of cause of leath? Other: ed Washington, IX as stated. lue to the cause(s) ed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	- For State Registrar Amend 20b, per		-				lental Hyg R 2. Date of Deat	eg. 12	007	29543				
Physicia /Medica	n al	1. Decedent's Name (First, Middle, Last) Thomas K.	Johnson	1				September 1	Day	0 2007	1 2:15 R M				
Examine uneral irector		243-42-7130	gton Medi	cal Cer (In yrs. last b	nter	Glen Bu	ocation of Death IMPIE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Ar Year)	ounty of Dea ne Aru 9. Bir 1929 V					
how		Usual Residence of Decedent 10a. State 10b, County		10c. City, Tox	wn or Location						10d. Inside City Limits				
el', or items 23a or 28e-f show Exsericer coust be rediffed at	Director	Maryland Anne Arui	ndel	Gle	n Burn				O- Citio	and Milhart C	1 Yes 2 No				
ather		6507 Clear Drop M	lay. Unit	102	101.	Zip Code 2106	50	1	-	en of What C	ountry?				
NE TRUE LON	by Funerai		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S.			eanic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Am Black, Whi Specify: W	ite, etc.				
avant, Ine Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation			work done dur Tuse retired)	on ing most of worki	ing		d of Business	,				
ant, to	Be Co	17. Father's Name (First, Middle, Last)			Supe	rvisor	8. Mother's Name				nsportation				
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	i	19a. Informant's Name/Relationship (Ty Dorothy P. Johnson	•				d Number or Rura				<i>zip cod</i> e) nie, MD 21060				
		20a. Method of Disposition 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)		20b. Place cemet	of Disposition (ery, crematory	Name of or other place)		Date 2007	20c. Loc	ation - City or	Town, State Haryland				
once.		21. Signature of Funeral Service License	411	-1	22. Name	and Address	of Carolles	allings	Fune	eral Ho	ome, P.A.				
ian ical		23a. Part1. Enter the disease, o complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		nno	not enter the i	node of dying,	such as cardiac c	or respiratory arre	est,)_21324	Approximate Interval Between Onset and Death				
		EXa	edicai Examiner	Exa	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):	we A	Morem	ng dis	·ee,	se_	
detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal deat	h 3 □Ectopi 5 □ Other	c pregnancy (specify)			2	3d. Date of de Month	olivery Day Year				
pe d	ò	Part II. Other significant conditions cor	ntributing to death but	not resulting	in the underlying	ig cause given	in Part I.	23e. Did tob			o the cause of death?				
page 2	Completed							24a. Was a autops perform 1 - Yes 2	v	death?	utopsy findings available completion of cause of s 2 \sum No				
rect	To Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	lospital: 1 Inpatien	t 2□ ER/0	utnationt 3	DOA Other:	6. Place of Death			Other (Sne	aciń.)				
		27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Time of Injury	28c. Injury at Work?		28d. Describe ho			ony				
led in by t	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	arm, street, fac	tory, office		28f. Location (St. City or Town		Number or R	lural Route Number,				
completely tilled in by the funer	edicai	29a. Certifier (Check only one) Certifying Physical Medicel Examination	sician: To the best of ner: On the basis of e and manner state	examination a	ge, death occur nd/or investiga	red at the time, ion, in my opin	date and place, a ion, death occurr	and due to the ca ed at the time, da	ause(s) a ate and	and manner a place, and du	s stated. e to the cause(s)				
Боо	Σ	29b. Signature and title of certifier	m			DH	3977	S 2	e Ve	signed (Mon	th, Day, Year) 10 200 7				
	(20. Name and address of person who co	mpleted cause of dea	ath (Item 23a)	(Type, Print)	priè	Glen	Brown))	mp	. 4061.				
Stat		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	to An	well !	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMIND TIPM/8, perFH C8/1, 9/14/07, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10 AM KLINE SEPTEMBER GEORGAN 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL OF BALTIMORE N/A BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 943 | Months | Days | Hours | Min. | 05/29/2007 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 219-40-5947 64 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 No BALTIMORE BALTIMORE MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2305 BAYTHORNE COURT 21209 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 X No Specify. Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Item 27 is marked other than "nature other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " College (1-4or 5+) 5+ Elementary/Secondary (0-12) HEALTH CARE NURSING RECRUITER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be BERRYMAN IGNOZZI WILMA GEORGE P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 BAYTHORNE COURT - BALTIMORE, MD 21209 19a. Informant's Name/Relationship (Type. Print) MAURICE KLINE / HUSBAND Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages CARROLL CREMATION, of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once, = 5 09/12/2007 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mast La 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER OVARIAN **Physician** METASTATIC YEARS /Medical Due to (or as a consequence of): **Examiner** MONTHS LEUKEMIA MONOCYTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 | Yes 2 No 3 | Probably 4 | Unknown RENAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ANEMIA performed2 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ^L After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury funeral 27. Manper of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 124 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 11 2007 ml C. NES-000 Aunti 30. Name and address of person w/o completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE NEUSA s. Municio, M.D. ANNA SINAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 4 2007

DHMH 17 Rev 1/2001

Registrar

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PA

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Certificate of Death

Reg. No. 2007 2. Date of Death Day

Physician /Medical Examiner
Funeral

Director ms 23a or 28a-f show must be notified at

filed within 72 hours after death with the Maryland "natural", or Items Baltimore, Maryland 21215-0036 other traumatic event, permit. Pages 1 and 2 Department of Health a Important: If it any injury or c

> **Physician** /Medical Examiner

attending physician and for use as the burial-trar death certificate be been signed by the should be detached has

page 2 s Director: After within 24 hours a To the Funeral C

1. Decedent's Name (First, Middle, Last) Month 09 2007 Anna J. Kovasznay 12:54p ^M 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Center for Hospice Towson Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 F 213-30-9146 87 Hungary Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore MD Towson Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1055 W. Joppa Rd. #717 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify.White 9 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Librarian School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lajos Frenyo Jolan Bakacs ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beatrice Kovasznay/daughter 6 Colonial Av.Albany, NY 12203 20a. Method of Disposition
1 ☐ Burial 2 ©Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9-14-2007|Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 8717 Green Pastures Dr. 21. Signature of Funeral Service Licensee mo1358 Cremation & Funeral Sv.Towson,MD 21286 23a. Part f. Enter the Jsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic Immediate Cause (Final Breast CANCER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed 2 No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5250 670, N- Charles St. Balto. Md 2124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 64mc 31. Date filed (Month, Day, Year) SEP 1 32. Registrar's Signature State 14 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician September 8, 2007 Marie Fuger Lewis 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F 375-46-6476 Philippines Director 95 July 28 1912 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anote. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director MD Baltimore Ruxton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 922 Army Road 21204 Funeral USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick William Fuger Marie Archange Hall မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander I. Lewis III son 922 Army Road; Ruxton, MD 21204 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Hilltop Service Corp. 9/12/07 4 ☐ Donation Other (Specify) Towson, MD 21. Signature of F 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cau Immediate Cause (Final SCHEMIC CARDIOMYORATHY Physician UE-ARS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 → nknown Be Completed STROKE Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s CORONARY ARTERY DISEASE 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Ther (Specify) HZSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Yolo Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DANIEUE DOBERMAN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D64395

MO 6565 NOHARUS ST; SUITE 216 BALTIMOTE, MO 21204
32. References Signatures S

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTP: 429d, per PHYS. 08/1 9/14/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) MCCASKILL Day **Physician** KENE 29 000 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day Sept.// Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Yrs. Director 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 📉 ves 2 🗆 No **Funeral Directon** more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 1No Specify: Completed by 3 Widowed 4 Divorced at 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Mental Hygiene. Important; if item 27 is marked other the any injury or other traumer. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type. Print) (Mother) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, 105 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Dav 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 3 Probably 4 Dunknown 1 🗌 Yes funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 🔲 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MYGUICIAN 7543 8-30-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MOX1223 SANDHU BALTIMORE 57 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 14 Registrar 2007

07-07038	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Lymaris Mejias	State of Maryland / Department of Health and Mental Hygiene
	1- For State Certificate of Death Reg. No. 2007 2951
Physician	2. Date of Death
Medical Examine	- L/MACIS (VEL) AS September 10, 2007
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	6811 Dunbar Road Dundalk Baltimore County
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign New
Director	597-24-8327 1 M 2 XF 29 Yrs. Months Days Hours Min. Jan. 25.1978 Country) Jersey
	Just Palitage of Product
any	10a. State 10b. County 1 10c. City, Town or Location 10d. Inside City Limits
ž!	Md MA Tundalk
yland yland once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the Maryland a or 28a-f sh	101 to DI 21222
death with the Maryland or items 23a or 28a-f show must be notified at once.	
h wit	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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5-0036 led within 7 led within 7 led within 7 led than than the Medica	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Home maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Hyg Hyg d oth	
21215-003 uld be filed within in Mental Hygiene, is marked other the cevent, the Medi	III COM STATE CONTRACTOR CONTRACT
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once the control of the	19a. Informant's Name/Relationship (Type, Pint) mother 19b. Mailing Address (Street and Namber or Rural Route Number, City or Town, State, 2p Code) MCG Full Charlotte N. C. 28213
e, MD 1 and 2 sho Health and item 27 is	11/13: Lugeria Titari Town State
Fe, THea	20a. Method of Disposition
- A 0 F L	1 Departies 5 Other Specific Share Specific
Baltimore, permit Pages La Department of He Important: If injury or other trees injury or other trees.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility S. Funeral, Home, P.A.
Det Det	1 1 W/1 (1) h . Ox : 1 W/1 VV 12222 W North Ave. 13a173. 14d: 21216
Physician	23a. Fat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiacor respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Madical	Curphot Wound of Hoad
taminer	Immiliate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
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	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	and the state of this control of the state o
sit q	to auss. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
and ecui	
ਰ ਸ਼ਿਵ	UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown AMENDED AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 4 Pregnant at time of death 5 Other (Specify)
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	IF FEMALE: 23d. Date of delivery 23d. Date of delivery 23d. Month Day Year
68 ertifi	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
ox ath c	1 Yes 2 No 9 V Unknown g Unknown
. D . the de de the de de the de de the de	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. rate of Attending Physician: The law requires that the rs after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	1 Yes 2 ✓ No 3 Probably 4 Unknown
S, F uires n sign Id be	
y red	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 26 Place of Death (Check only one)
ecc ne lav te ha	1 ✓ Yes 2 No 1 ✓ Yes 2 No
tifica	25. Was case referred to medical 26.Place of Death (Check only one)
irecto	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4 Nursing Home 5 Residence 6 Other: Scene
ion of Vital tending Physician: death. ttor: After this certify the funeral director,	O 1 ✓ Yes 2 No Impatch 2 28b. Time of Injury 28b. Injury at Work? 28d. Describe how injury occurred
ding h. Aft	28b. Date of Injury 5
Sio Atten deat cetor	Sep 10, 2007 0547 hrs Investigation Sep 10, 2007 0547 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
or /	or Town, State) 6 Could not be determined (Specify) Single Family 6811 Dunbar Road, Dundalk, MD
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Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should le	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
o the	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
FSFÓ	2 29b. Signature and title or continu
	O.C.M.E. September 11, 2007
-	30. Name and address of person who completed cause of death (Item 23a)
	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
V C	100 GRajatura Simplura
Regist	AT 1 1 2007 No. 25 No. 26 No. 26 No.

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State of Maryland / Department of Health and Mental Hygiene

2007 29549

		1-For State Registrar Amend #19b Per FH G877110110000000000000000000000000000000	th i	Reg.	No.	
Physicia	n/	Decedent's Name (First, Middle, Last)		Date of Death Month	ay Year	3. Time of Death
' 'cal Examin		Lisa Glaffe Hadu	Town or Legation of Dooth	September	11, 2007 4c. County of Death	1519 hrs
			Town, or Location of Death		n/a	
Funeral	٩		der 1 Year If Under 24Hrs.	. 8. Date of Birth(MM/DD/YYYY) 9. Bir	thplace (State or
Director		216-92-1488 1 M 2XF 28 Yrs. Mont			Foreig	
	ŀ	Usual Residence of Decedent		12,037		2
any	f	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	٦	MD Baltimore Parkville):	1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zi	ip Code	10g	Citizen of What Cou	ntry?
the N		1007 1107 Halstead Rd., Apt T-1 2	1234	Fa. 155	U.S.A.	
ı with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto			ican Indian, Black,
death or ite	Ĕ	X 1 Yes 2 X No		rican, etc.)	White, etc.	o.lr
after	à	or Dates:	2 X, No specify:		Specify: Bla	
hours 'natnı		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua during most of w	al Occupation (Give kind of vorking life. DO NOT use reti		6b. Kind of Business/	Industry
136 thin 72 re. than "	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Security	Supervisor		Hospita	1
-00 J with	E .	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Linwood Coleman	Che	rv1	Mer	chant
21.2 build b Men mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	ss_ (Street and Number or F	Rural Route Number	er, City or Town, State	e, Zip Code)
MD ad 2 shoulth and an 27 is aumati		Charles Madu-husband 1107 Hal	ss (Street and Number or F alstead Road stead Rd., A	apt-1 1	Balt., MD	21234
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours aften of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.		20a. Method of Disposition 20b. Place of Disposition (Na	ame of cemetery,	Date	20c. Location - City or	Town, State
MOI Pages ent of nt: 1		1 X Burial 2 Cremation 3 Removal from State crematory or other plac Woodlawn Cem		/17/2007	Woodlawn,	MD
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other trinjury or other traumatic event, the Med	1	21. Signature of Funeral Service Licensee 22. Name an	nd Address of Facility Le	eonard J.	Ruck, In	c.
E.F. P. B.		William G. Dau 5305	Harford Rd.,	Baltimon	re, MD 21	204
Physician		23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	e of dying, such as cardiad o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
'Medical ≟xaminer	1	Immediate Cause (Final disease a. Head and neck injuries	3 20			Death
		or condition resulting in death) Due to (or as a consequence of):	4	4.		
	<u>ا</u> ة	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	Couse Enter Underlying Couse (Disease or injury that initiated				
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760, icate be graphysiciate the buria	Medical	UNPENDED X AMENDED #10e_DerFH_g872_10/23/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	<u> </u>
rtifica ing pl	ician/	DOL Mary developed and an experience of the	th 3 Ectopic pregna	ancy		Day Year
Box 68 steath certification attending and for use as	70	1 Ves 0 Ne 0 is I Helmoure	pecify)			
D. B.	E S	Part II. Other significant conditions contributing to death but not resulting in the underlying	no cause given in Part I.	23e, Did tob	acco use contribute to	the cause of death?
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	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3	26.Place of Death (Check		esidence 6 Othe	er:
fing Physi After this funeral dir	£	27. Manner of Death 28a, Date of Injury 28b. Time of Injury	28c. Injury at Work?		w injury occurred	
ion c tending eath tor: Af	틾	1 Natural 5 Pending Sep 11, 2007 1333 hrs	1 Yes 2 ✔ No	Driver auto fix	xed object(s) col	lision
S 4 5 5 5	ertification:	2 M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, facto	ory, office building, etc.			ural Route Number, City
Divis Hospital or / 24 hours after Funeral Dire	딍	Suicide 6 Could not be determined (Specify) Local Street		or Town, Sta 3900 Blk. Loch	ite) Raven Blvd, Baltin	nore, MD
Hosp 24 hor Fine tely fi	اء ا	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the Company of the Compan	he time, date and place, and	due to the cause	(s) and manner as sta	ted.
Divi	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in rand manner stated.	my opinion, death occurred a	at the time, date a	nd place, and due to t	he cause(s)
FSFS	ŝ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
1		Treshe Deley Um	O.C.M.E.		September 12,	2007
10	Ì	30. Name and address of person who completed duse of death (Item 23a)	04	D 04004		
U			Street, Baltimore, Mi	D 21201		
Sta Regist		31. Date filed (Month, Day, Year) 32. Segistrar's Signature	,			
DHMH 17 Rev 1/20		OCME ORIGINAL				

				Please T	ype or Prin						•		_egible.		
			For 1_ State		State of Ma	aryland /					Mental Hy	giene			
-			Registrar 1. Decedent's Name (F	First Middle Last)			Cei	tificate	or i	Death	2. Date of De	Reg. No.	$\cdot \cup \cup I$	295	50
,	Physici /Medic	_	· ·	rwin Ma	arshall						SEPTERL		100	7 8:401	A. M
	Examir		4a. Facility Name (If no	t institution, give s		YSTEM		4b. City, T	rown, o	Location of Death	NT	4c.	County of Dea	e/L	
	Funeral Director		5. Social Security Numl 368 . 12 . 8	1 10	7. Age	e (In yrs. last i	birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	Birth Day, Year) 9. Birthplace (State or Foreign Country) 1 N			oreign
	and w		Usual Residence of De			10c. City, To	own or Lo	cation						10d. Inside City L	imits
	Manyla f sho	tor		Harford	1		rde							1 □ Yes 2	
	or 28a	irec	10e. Street and Numbe					10f. Zip (Code			10g. Citiz	en of What C	ountry?	
`	23a c	ral	300 Stev					210					S.A.		
336	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 ⑤	→ Married	12. Was Decedent I Armed Forces? 1 Yes 2 In If Yes, Give Year or Dates:	No 1 ☐ Yes 2 ☐ No Specify:					pecify Yes or No o Rican, etc.)		14. Race - Am Black, Whi Specify: W	ite, etc.	
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d 2	filed withir Hygiene. other than ent, the Me	Be Co	17. Father's Name (First	st, Middle, Last)	<u> </u>		Dar			18. Mother's Nam	ne (First, Middle			Lovemen	<u> </u>
/lan	12 should be f n and Mental I is marked of raumatic eve	To B	Henry Ja	mes Gio	vanini					Thresa	Jean	Elle	r		
Maryland	12 sho		19a. Informant's Name							and Number or Ru					
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nor	S to I		1 ☐ Burial 2 ☐€ 4 ☐ Donation 5	remation 3 🗆 R	emoval from State	1				1	10.07				
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) Chesapeake Crem. 09.10.07 Beltsville, MD 21. Signature of Funeral Service Licensee												
	Physician /Medical		23a. Part1. Ent in he c shock, or he art fa Immediate Cause (Fin- disease or condition resulting in death)		cations that caused le cause on each lir	TIVE I	YEART	FAIL	of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Betwee Onset and Dea	
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Δ.	res that igned by be deta	by Ph	Part II. Other significa	nt conditions con	tributing to death be	ut not resulting	g in the u	nderlying ca	iuse giv	en in Part I.	23e. Did	tobacco u	se contribute	to the cause of dear	th?
ords	w require been sig should b										1	Yes 2	No 3∏F	robably 4 Donk	cnown
or Vital Records,		Completed									24a. Was auto perl 1∏ Yes	opsy formed?	24b. Were a prior to death? 1 □ Ye		ailable se of
Vit	Physician: The this certificate ral director, pag	Be	25. Was case referred examiner?	11	lospital:				, Oth	26. Place of Dea					
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ion	Attending I r death. ector: After by the funer	atio	2 Accident	Pending investigation	(Month, Day	y Year)	Injury	М		k? Yes 2 ☐ No					
Division	spital or Attend tours after death neral Director: / filled in by the f	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of injubuilding, etc	ury - At home, c. (Specify)	farm, str	eet, factory,	, office		28f. Location City or To	(Street and own, State)	d Number or F)	Rural Route Numbe	r,
	6 # □ 은	Medical	29a. Certifier 1 (Check only one)	CertifyIng Phys Medical Examin	sician: To the best oner: On the basis of and manner sta	examination	dge, deat and/or in	n occurred a vestigation,	at the tir in my o	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner a place, and du	as stated. ue to the cause(s)	
\ \ \	To the within 2. To the complet	M	29b. Signature and title	of certifier	7			29c.		DSL739		29d. Date	e signed (Mor	nth, Day, Year)	
1.1	17		30. Name and address	of person who co	mpreted cause of d					CARE SYS	rem he	RRY P	AINT M	n 11an1	
1,	Sta	ite	31. Date filed (Month, SE	Day, Year) P 1 4 201	32 Registra	ar's Signature	THAND	IIIII	NII	CIN OID) PF	rki I	V'111) 111	A NILAN	
	Registr	ar	SE	T + 4 ZUI	OI JULIA	So So	1	Walk P							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar		Ce	rtificate of I	Death	R	eg. No2 0 0 7	29551
70		<u> </u>	1. Decedent's Name (First, Middle,	,				Date of Deat Month	th Day Year	3. Time of Death
	Physicia /Medic		Jacqulina	L. M	akell			09/09	/2007	1950 P M
	Examin	- 2	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	ath
V.	4	3 4	Gladys Spell	nan Special	ty	Cheve:	rly I If Under 24 Hrs.	O Date of Birth	Prince	Georges
i.	Funeral		5. Social Security Number 226-54-0470	4 CT M OFFE	n yrs. last birthday) 4 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	, Year) 9. Bl	rthplace (State or Foreign country)
	Director		Usual Residence of Decedent	0	4			04/02/	1943	DC
	yland iow at		10a. State 10b. County	10	Dc. City, Town or Lo					10d. Inside City Limits
	A-f st	iç	MD Prince	e Georges	Che	verly				Y☐Yes 2☐No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	country?
	23a ust b	ra [2900 Mercy La			2078			U.S.A.	
	tems ter m	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🌠 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 █ \ No	Specify:		Specify:	Black
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	pa	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation	- 1	16b. Kind of Busines	s/Industry
212	hin 72 In "na Media	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor. d)	king		
212	d with giene ar tha the	Completed	12	Conlogo (1 Tol o 1)		Nurse			Privat	e
b	al Hy al Hy fother vent,	Be	17. Father's Name (First, Middle, L.	•					Maiden Surname)	
yla	Duld to Ment arked arice	မှ	Un-Knov				Louise		Burton	
Maryland	2 sho and is m raum		19a. Informant's Name/Relationshi			•			r, City or Town, State,	. ,
	1 and lealth am 27 ther tr		Jeanette West		9689 20b. Place of Dispo	_	Crest C		na, MD 21	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 【Cremation	3 □Removal from State	cemetery, cre	matory or other plac	1 1	. 1	ŕ	
Ħ	it. Partmei		4 □ Donation 5 □ Other (Sp.		Riverda				Riverdal	e,MD Funeral Hm
Ba	permit. Page Department of Important: If any Injury or once,		inclu to	wa I					timore,M	
	76		23a Part1. Enter the disease, or c shock, or heart failure. List b	/ 1 1/						Approximate
	Dhysiolon		Immediate Cause (Final	nly one cause on each line.	f	1 /	10.	4:00		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	onsequence of):	£ 70	- th	NC		100.
h	Examiner				Low	200				lwk
		Je.	Sequentially list conditions,	Due to (or as a co	on unence of		1 . 01	1-0		1 0 0 0
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	righ	1- KE	29	4-words			
Ö,	e exe ian a urial	m	resulting in death) Last	Due to (or as a c	o/isequence (of):		/		7.	
8760,	ate b	dical	'	d						
9	leath certific attending p	0	IF FEMALE:	23c. If yes, outcome pf p	pregnancy				and Data of d	-11
. Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	□Fetal death 3[⊒Ectopic pregnancy ⊒ Other (specify) _	у		23d. Date of d Month	Day Year
o.	the de	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown	ne or death 5					
<u>م</u> ّ	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/ Ph	Part II. Other significant condition	s contributing to death but p	ot resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires n sigr ald be	d by	Lessin	iliny 7	toilo	we		1 □ Y	es 2□No 3□	Probably 4 Hiknown
00	s bee	lete	Hypor	rather	ica			24a. Was a		autopsy findings available
æ	The la te has age 2	Completed	1 Le	in - Right	Dea	vdev.		autop: perfor 1∐ Yes	med? death'	o completion of cause of es 2 □ No
ta	rtifica ttor, p	BeC	25. Was case referred to medic.				26. Place of Dea	ath (Check only or		25 25110
>	nysic nis ce direc	ToE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 R/Outpatie	nt 3□ DOA Oth	ner: 4 Nursing H	lome 5 ☐ Resid	ence 6 Other (Sp	pecify)
0	ng Pł fter tł neral	Ë	27. Mann of Death atural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury	of 28c. Injui Wor	ry at rk?	28d. Describe h	ow injury occurred	
Sio	tendi eath. or: A the fu	atic	2 ☐ Accident investigation in	ation			Yes 2 ☐ No			
Division or Vital Records, P.	or At fter d Jirect in by	Certification:	4 Homicide determin		 At home, farm, st 'Specify) 	reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	pital ours a urs a eral E		20a Cartifiar 15 Cartifuina	Physicians To the heat of s	my knowledge dea	th accurred at the ti	me date and place	and due to the	naueo(e) and monnor	as stated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	edical		Physician: To the best of n xaminer: On the basis of ex and manner stated	kamination and/or in					
	o the orther orther omple	Mec	29b. Signature and title of certifier	0 0 0 0 1 1 16	7.,	29c Licens	se number	1 1 D	29d. Date signed (Mo	nth, Day, Year)
\	F > F 0		2 KA	eeer ()	2	- 1016	273	Mes.	2/10/	64
,			30. Name and address of person w	/ho/completed, cause of deat	th (Item 23a) (Type	Print)	/	1-	DI	Longles
			KT2 MATHY	LIWKTH.	7 , 1	5/30	Lauca	CVOV	1 a C	mot

State Registrar 31. Date filed (Month, Day, Year)

SEP 1 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29552

		1- For State Registrar	Certifica	ate of De	ath			Reg. No.	200	1 2533
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)					2. Date of De Month		Year	3. Time of Death 1247 hrs
viedicai Examir	ier	Doris Emma Nechamk 4a. Facility Name (if not institution, give street and number)	(in	4b Cit	y, Town, or L	ocation of		Day per 12, 200	07 unty of Death	1247 IIIS
		8800 Walther Boulevard #3307			rkville				more Cou	nty
Funeral			yrs. last birt	- ' -	Inder 1 Year	If Under		Birth (MM/DD/	YYYY) 9. Birt Foreig	hplace (State or
Director		212-30-6427 1 _M 2XF 74		Yrs.	onths Days	Hours .	March March	6, 19		^{intry)} Maryland
- Inter	F	Usual Residence of Decedent 10a. State 10b. County 10c	City, Town	or Location						10d. Inside City Limits
<u> </u>		Maryland Baltimore	•	<ville< th=""><th></th><th></th><th></th><th></th><th></th><th>1 Yes 2 No</th></ville<>						1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number			Zip Code		, .	10g. Citizen	of What Cour	try?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	<u></u>	8800 Walther Blvd. #3307		21	234		10.00	USA		
h with	Funeral	11. Marital Status 12. Was Decedent Eve	r in U.S.				in? (Specify Yes or N Puerto Ricán, etc.)		Race - Ameri White, etc.	can Indian, Black,
er deat	틸	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Yeer	No	-	-				cify: Whi	+-
ırs afte tural" ıminel	ē.	15. Decedent's Education (Specify only highest grade complete	ed) 16a.	1 Yes Decedent's Us		specify: on (Give k	ind of work done		of Business/I	
27 3 🖃	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	<u> </u>	during most of					-	1
0036 within 72 giene. her than "	립	2	1	Executi						y Shipyard
filed v filled v I Hygi ed offh t, the		17. Father's Name (First, Middle, Last) Solomon Nechamkin			11	_	s Name (First, Middle ma Hi	, Maiden Suri =il	name)	
7 무운 등 3	o Be	19a. Informant's Name/Relationship (Type, Print)	191	. Mailing Addr	ess (Street		ber or Rural Route N		r Town, State	Zip Code)
AD 2 sho	-	Sheri Kimmel / Niece					ins Rd. T			
ore, M es I and 2 of Health If item 2 her traun	Ī	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		of Disposition (etery,	Date	20c. Loca	ation - City or	Town, State
Pages nent of ant: If	-	4 Denation 5 Other Specify	Park	Jood Ce	metery	,	9/17/07	Parl	kville	, Md.
Baltimore, permit. Pages I an Department of He Important: If ite important: If ite injury or other tr	Ī	21. Signature of Funeral Service Licensee			and Address			-	1050 Y	ork Road,
	4	233. Part I. Enter the disease, or complications that caused the	death Dono				eral Home			Approximate Interval
Physician /Medical	Į	failure. List only one cause on each line.			ac or aying, s	den as de	adiac of respiratory e	irest, sriook,	or ricurt	Between Onset and Death
.xaminer		Immediate Cause (Final disease or condition resulting in death) a. Castrointesti Due to (or as a conseque		ormage						
	_	Sequentially list conditions, b. Bleeding dive		-						
	nine	the to (or as a consequence). Enter Underlying Cause (Disease or injury that initiated	neo 21):							
ed sit	Examiner	events resulting in death) Last Due to (or as a conseque	ence of):							
1 0 c		UNPENDED			070.10/	1 /07 0	m			
60, ate be hysicia	Medical	IF FEMALE: 23c. If yes, outcome o		perME,g	3872 , 10/.	1/0/ .	11	23d. Da	ate of delivery	
ox 68760, eath certificate be attending physici for use as the buri		23b. Was decedent pregnant in the past 12 months?	of dooth			Ectopic	pregnancy	Mo	nth [Day Year
Box 68: death certif	Physician	1 Yes 2 ✓ No 9 Unknown 9 Unknown	e or death	Other (Specify)					
		Part II. Other significant conditions contributing to death but	t not resulting	g in the underly	ying cause giv	ven in Pa				the cause of death?
ires that to signed by the detact	g b	Anticoagulatant therapy, nasal f	racture	with he	morrhag	е	1 Y	es 2 🗸 No	o 3 Prot	ably 4 Unknown
cords, law requii	Sete							opsy	prior to o	topsy findings available ompletion of cause of
Reco	Completed by							formed?	death? 1 ✔ Ye	s 2 No
	Be	25. Was case referred to medical examiner? Hospital: 1 Innation			10	of Death (Check only one)			
of Vital I ling Physician: After this certifi funeral director,	의	1 ✓ Yes 2 No Inpatient 27. Manner of Death 28a. Date of Injury		utpatient 3 Time of Injury	DOA 28c. Injury		Nursing Home 5	Residence	6 Other	Scene
ion of tending Pt eath. or; After the funeral	<u>[</u>	1 Natural 5 Pending Food 0/12/200	.	· · · · · · · · · · · · · · · · · · ·	I	es 2X				
Division tal or Attendi rs after death. al Director: led in by the fu	fica	2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury		ırm, street, fac	tory, office bu	ilding, etc	c. 28f. Location	(Street and I	Number or Ru	ral Route Number, City
Divis spital or At ours after d teral Direct filled in by	Certification:	4 Homicide determined (Specify) HOT	ne				8800 Wa	lther B1	vd. Parl	wille, MD
3 - 5	- 1	29a. Certifier (Check only 1 Certifying Physician: To the best of my kn one) Wedical Examiner: On the basis of examina	_							
To t with To com	Medical	2 Medical Examiner: On the basis of examine and manner stated. 29b. Signature and title of certifier			29c. License					nth, Day, Year)
	_	() (dante esso)			O.C.N	1.E.		Septer	mber 13, 2	007
0/3	-	30. Name and address of person who completed cause of death	(Item 23a)				· · · · · · · · · · · · · · · · · · ·			
0 1	_	Laron Locke MD. Assistant Medical Exami	ner 11	Penn Stre	eet, Baltim	ore, MI	D 21201			
Sta Registi	~~	31. Date filed (Month, Day, Year) 32. Registra 3	ignature	4 fo	and s					
DHMH 17 Rev 1/20		OCME 2007 CSG	<i>₩. ~</i>	IGINAL						
OCME 2006			0.11							

<u>3111 Mountain Rd., Pasadena, MD 21122</u>

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Department Important: If any Injury o

Physician

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Examiner

Directo

Funeral

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Funeral

Director

item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic event, the Maxical Examinar must be notified at

2 should be filed within 72 hours after nand Mental Hygiene.

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Pages 5 = 5

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Maryland 21215-0036

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attending physicien and for use as the burial-transit been signed by the should be detached certificete has b irector, page 2 sl s efter deeth.

I Director: After this certifice of in by the funeral director, F.

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completely

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24 hours e Funerel (

within 2 To the I ţ

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Hospital or Attending Physician:

23a. Parts. Enter the disease or complications that caused the dishock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aherosclerotie ardio voscular disease mus. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 応 No 24a Wasan autopsy 3/ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28365

Registrar DHMH 17 Rev 1/2001

State

368 nucl

32. Registrar's Signature

A ROBERTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAPI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of Ma	-	epartmer <i>Certifica</i> :				giene _{Reg. No.} '	2007	20551		
ę	Physicia	_	Registrar 1. Decedent's Name (First, Middle, La Mary		s Norc	ross,	Jr.		2. Date of De Month Septem	Dav	Year 2007	3. Time of Death 12:20 PM		
	/Medic Examin		la. Facility Name (If not institution, giv		is note			Location of Death	Jor		ounty of Death			
	LAGIIIII	8	14304 Brickhowe	Court				ntown			ntgomer			
E	Funeral Director		5. Social Security Number 6. \$ 142-24-5076	VIM SIDE	(In yrs. last birtl	hday) If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da February	ıy, Year)	Cou	nplace (State or Foreign Intry) Jersey		
\$	pu »	H	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits		
	faryla shov ed at		Maryland Montgom		_	antown						1 ☐ Yes 2 X No		
	the N 28a-1 notifi	rect	10e. Street and Number	CLy	001		ip Code			10g. Citize	en of What Co	untry?		
	3a or st be	Funeral Director	14304 Brickhowe	Court				20874		Unit	ed Stat	es		
٥	IIIU Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give	· 1952-	13. Was Dec		spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	- 1	4. Race - Amer Black, White Specify: Wh	e, etc.		
5-0036	72 hours and an arthral", o	sted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E (Specify only highest gr	Year or Dates:	1986	Decederate He	ual Onoun		king		d of Business/			
Z	within 7 ene. than "r he Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-1 1	`life. DO NOT eterina:)		Vete	rinarv	Medicine		
2	filed w Hygier other th		17. Father's Name (First, Middle, Las	5+		s c c c c c c c c c c c c c c c c c c c	Tan	18. Mother's Nan	ne (First, Middle					
ano	lid be f fental l rked of	o Be	Marvin Augustus		Sr.			Kathe	rine Mc	Guiga	n			
Maryland	es 1 and 2 should be of Health and Menta fitem 27 Is marked r other traumatic ev	ပ္	19a. Informant's Name/Relationship	(Type. Print)		-		and Number or Ru						
	and 2 salth a 27 is		Joan N. Norcross	/ Wife								and 20874		
altimore,	Pages 1 and the present of the prese		20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			Disposition (Nry, crematory of edom Ce	emete	ry 17.	tember 2007	Tansl		ew Jersey		
Balt	permit. Pages 'Department of H Important: If Ite any Injury or of		21. Signature of Funeral Service Lice	(T	401305	Robert 300 Wes	and Addres A. Pun t Mont	s of Facility phrey Fune gomery Ave	ral Home, nue, Rock	/Rockv	ille, Ind Marylan	d 20850–2805		
	*		23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwoen the cause (Final disease or condition) Multiple Myeloma 4 Years											
,	Physician /Medical		disease or condition resulting in death)	_ a	a consequence							7 10010		
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O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) 9 □ Unknown 9 □ Unknown						23d. Date of Month			livery Day Year		
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ital		Be C	25. Was case referred to medical examiner?				100	26. Place of De	ath (Check only	one)				
× <	Physician: r this certific ral director,	100	1 ☐ Yes 2 💢 No	Hospital:				4 🗆 Nursing i	-lome 5 X Re			ecify)		
n C	ling P After t unera	<u>.</u>	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Time of Injury M	28c. Inju Wo	ryat rk? ∣Yes 2∐No	260. Describi	a now injur	y occurred			
)ivisio	or Attending ifter death. Director: After in by the funer	Certification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e Place of init	ury - At home, fa c. (Specify)				28f. Location City or T	(Street and own, State	d Number or F	Bural Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Ce	29a. Certifier 1 X Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination a	e, death occur nd/or investigat	red at the ti	me, date and plac opinion, death occ	e, and due to the	ne cause(s) e, date and	and manner a d place, and du	as stated. ue to the cause(s)		
		Med	29b. Signature and title of certifier	7/200 F	mn		29c. Licens	34163		29d. Dat	te signed (Mor	oth, Day, Year)		
•	1541		30. Name and address of person who Carolyn J. Harr:	Marker of complete of complete on , M.D.	leath (Item 23a)	(Type, Print)	stown	n Road, I	arnesto	own, N	/ <i>"/"1</i> Marylan	d 20878		
1	Si Regis	ate trar	31. Date filed (Month, Day, Year)	20 Post	rar's Signature									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09/10/2007 **Physician** Charlotte Olson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 4100 Benson Avenue Halethorpe Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2√2 F 87 Illinois 331-16-3712 8/27/1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo MD Baltimore Halethorpe 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 4100 Benson Avenue Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2∕∏ No ive 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2XNo Saltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced "natural", Il Hygiene. other than "natura rent, the Medical E 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own home Homemaker Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hannah Hill Jesse Littlejohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1006 St. Charles Avenue, Baltimore, MD 21229 Nancy Olson / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 9/14/2007 Elkridge, Maryland 21. Fignature of Euneral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER YEAR **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown CORONARY ARTERY DISEASE Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No ATRIAL FIBRILLATION HYPERTENSION 24a. Was an was autopsy performed? Yes 2 No ABDOM INAL HORTIC 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3

☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 and manner stated.

15 State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 1 4

SOUN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

KIM

DHMH 17 Rev 1/2001

29c. License number

5808 MAIN STREET, ELKRIDGE, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4c. County of Death ptember undin vauc /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 050 if Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, 9. Birth **Funeral** Days 1 ☐ M 2 🗙 F Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show raumatic event, the M-dral Examiner must be notified at 1X Yes 2 □ No Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5. A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify. 3 Widowed 4 Divorced Specify Black

16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Vocate 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event; 17. Father's Name (First, Middle, Last) Be Brooks မ 355ie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husbon 4403 Anntana Avenus Baltimore, mo 21206 Chwaye alim 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 09.13.2007 Baltimere. 4 Donation 5 Dother (Specify) Joodlaun 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Voughn C. Green Junhu Servie 8728 Liberty hoad handallstown mo 21133 Vaugh 23a. Part1. En eithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical e to (or ke a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ITON Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2∏ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 2 ☐ No 2 No To Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 29a. Certifier 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) ames 000 82 Registrar's Signature State Registrar

Alexander Pulignanii Baltimore, Maryland 21215-0036

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	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Locati	on of Death		4	4c. County of I	eath		
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	Funeral		Social Security Number 6. S			If Under 1 \ Months D	Year If Un	rs Min.	8. Date of Bi (Month, D	av. Yea	ar)	Birthpla Count	ace (State	or Foreign
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	er de item	Ĕ	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No	. 13.	Was Deceden If Yes, specify	Cuban, Mex	ican, Puerto I	Rican, etc.)	0-	Black, \			
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5-0036	72 hours after death w "natural", or items 23a idical Examiner must b	be	15. Decedent's Ed	lucation	16a. Dece	dent's Usual C	Occupation			16b.	Kind of Busin	ess/Indi	ustry	
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<u> a</u>	uld by Jenta rked tic e	10 E	Decio Joseph Puli	gnani				Aldovi	na Bre	scia	a			
Maryland	shot and N s ma	- 3	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (S	treet and Nu	mber or Rura	i Route Numi	ber, City	y or Town, Sta	te, Zip	Code)	
	Health a tem 27 is		Ronald Pulignani	(Son)	3 A	Brook	Farm	Court,	Perry	Hai	11, Mar	y1a	nd 21	128
Je .			20a. Method of Disposition		ace of Dispo	osition (Name matory or othe	of er place)	D	ate	20c.	Location - Cit	or Tov	vn, State	
E	Pages nent of H int: If ite		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		: Holy	Redee	mer	09/15	/2007	Bai	ltimore	. M	arvla	and
Baltimore,	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Licer		2	2. Name and A	Address of Fa	acility Sch	imunek	Fur	neral H	ome	Inc.	
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	V 155		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death.	Do not en	ter the mode of	of dying, such	as cardiac o	r respiratory	arrest,			Approxima Interval Be	ite etween
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	/Medical		resulting in death)	Due to (or as a consequence	ence of):	~	CALLE	W N				_		
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30	leath certific attending pi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3[⊒Ectopic preg					23d. Date of Month		y Day	Year
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P.0.	w requires that the d been signed by the should be detached	F.	Part II. Other significant conditions of	ontributing to death but not recul	ting in the u	underlying caus	e given in P	art I	23e Did	tobacc	o use contribu	te to the	a cause of	death?
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of my know niner: On the basis of examinati and manner stated.	neage, aear on and/or ir	nvestigation, ir	me time, dat my opinion,	e and place, a death occurr	aria aue to the ed at the time	e cause e, date a	and place, and	er as sta I due to	atea. the cause	(s)
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Registrar

Joseph

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Perkville, MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800 32 Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 1 4 2007

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND 11H#20b, perff, 871, 9/21/07, WS
State of Maryland / Department of Health and Mental Hygiene 29558 Certificate of Death Reg. No 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day Physician 8:08 PM ravis 10 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**X** M 2□ F 220-86-1671 Director Marylano 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumattc event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? - American Indian, 11. Mantal Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. porer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဥ 19a. Informant's Name/Relationship (Type. Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If item 27 is any Injury or are Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Balto. Crematory Coudon Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/25/07 Balto 4 ☐ Donation_ 5 Other (Specify) 22. Name and Address of Froility

JOSEPH L. RUSS FYNE

2222 U. North Fre. Fugeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or teart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Organ System Failure Approximate Interval Between Onset and Death 3 days Physician /Medical Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed Socral Ulcers the burial-trans Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 1 Yes 2 □ No 9 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ρ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပို 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury
(Month. Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: the Hospital or Attending 1 Natural 2 Accident 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KES-000 11,200] 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ka: Ku. mb. 4940 Eastern Avenue, Baltimore, mb. 21224 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Physicia /Medic Examin	a
Funeral Director	

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at n and Mental Hygiene. Department of Health an Important: If item 27 is many Injury or other

Saltimore, Maryland 21215-0036

2007

11,

SEPTEMBER

Physician /Medical Examiner

burial-tran physician a P.O. Box 68760, signed by t Division or Vital Records, After this certificate has been si funeral director, page 2 should 4 hours after death. filled in by

Hospital or To the Hospital or within 24 hours af To the Funeral D

State of Maryland / Department of Health and Mental Hygiene 29559 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav September 11, 2007 P^{M} Anna May Petr 2:47 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12-09-1921 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 💢 F Maryland 212-18-8527 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code U.S.A. 1813 Old Eastern Avenue 21221 Funeral . Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Weitherstein Joseph Dare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 Day Star Court Baltimore, Maryland 21206 Norbert R. Petr - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Parkwood Cemeterv 09-15-2007 Parkville, Maryland 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road hale-Baltimore, MD 21214 Unes Leonard J. Ruck, Inc. 23a. Part1. Enter the ilsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

ORIGINAL

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

Director

Funeral

2

Completed

Be (

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If Item 27 is marked other the any injury or other transment.

Maryland 21215-0036

Baltimore,

AGNES

attending physician for use as the burial certificate within 24 bours after deau.

To the Funeral Director: After this c this

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be (Certification: To

resulting in death) Last	Due'to (or as a conseque	ence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 □ Ectopic		230
Part II. Other significant conditions Hypertensio	•	ting in the underlying	cause given in Part I.	23e. Did tobacco use
				24a. Was an autopsy performed? 1∐ Yes 2 ☑ No
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27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury of

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1 🗓	Manner of Deati 1 ☑Natural 2 ☐ Accident	n 5	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	M 28	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	e how injury	occurred			
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		At home, farm, street specify)	t, factory,	office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
298	a. Certifier (Check only one)		nysician: To the best of m miner: On the basis of exa and manner stated.	amination and/or inves								
29b. Signature and title of certifier						29c, License number 29d, Date signed (Month, Day,)						

RES 000

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fang Y .. M.D.

Samaritan Hospital. 5601 Loch Raven Boulevard, Baltimore 31. Date filed (Month, Day, Year) 32. Registar's Signature

State Registrar

07-07054 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard M. Rosen State of Maryland / Department of Health and Mental Hygiene 1- For State 2007 29561 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year September 10, 2007 ROSEN RICHARD 1920 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Sinai Hospital **Baltimore** 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** oreign Director Davs 1/09/1943 216-42-2283 1 X M 2 F 63 Country) MD Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 No ΑZ SCOTTSDALE, AZ Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34106 NORTH 66th WAY 85262 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 4 X Divorced Give Yea Yes 2 No specify: WHITE Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **3altimore, MD 21215-0036** count. Pages 1 and 2 should be filed within ; epartment of Health and Mental Hygiene. ATTORNEY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSEN SELMA COHEN ISRAEL 19a, Informant's Name/Relationship (Type, Print)
RECTE REDITORITZ
LINDA KUSHER / SISTER ling Address (Street and Number or Rural Route Number, City or Town, State Zip Gulford Ave., Suite Asco Paltingre, 149, 212) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 Cremation 3 BALTIMORE HEBREW CONG Removal from State 09/12/2007 REISTERSTOWN, MD Donation 5 Other Specify 21. Sign are of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Enter the disease of Physician failure. List only one cause on each line. Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical #23a,PTI,27,perME,g872 Item/IOc.19a,b,perFH.(X UNPENDED X AMENDED attending physician or use as the burial Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Dav past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. as been signed by 2 should be detach 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 V No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) **Division of Vital** Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: d in by the f Yes 2 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4 Diversity of the state

DHMH 17 Rev 1/2001 OCME 2006 1

Zabiullah Ali, M.D.

31. Date filed (Month Day)

30. Name and address of person who completed cause of death (Item 23a)

Y4"2007

Assistant Medical Examiner

82 Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 11, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 2007 Month Day SEPTEMBER MAILLIAM ROBERTSON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1XM 2□ F 75 218-26-7903 JAN 16 1932 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ZYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3047 Fleetwood Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custom Picture Framer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Prince н. Robertson Marjorie Kemp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Robertson - wife 3047 Fleetwood Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【M Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/13/2007 4 Donation 5 Dother (Specify) Baltimore, MD 21. Signature of Funeral Service Ligensee Steven H. Williams ²² Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Klehsielfa disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MELLITUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1∐ Yes

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

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Funeral

Director

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item 27 is marked other other traumatic event,

Department of Important: If it any Injury or conce,

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and tems 23 aor 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Saltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records.

the burial-tran physician Physician/Medical as attending p for use as signed by the a d be detached fo þ Completed certificate ha funeral director. Be Certification: To After this

To the Hospital or Attending Physician: The law requires that the death certificate be executed n 24 hours at er dea h.

le Funeral Lirector: Af
bletely filled by the fur within 24 hor To the Fune completely fi

State Registrar

29a. Certifier

(Check only

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of cartifier

241410

29d. Date signed (Month, Day, Year)

21133

30. Name and order of person who completed cause of death (Item 23a) (Type, Print) JOGINDER MEHTA

17 25 PITAL CENTER TRANKINEST MHORLL TEWN

31. Date filed (Month, Day, Year)

Signature

						Cer	tificat	e of	Death		F	Reg. No.		
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Maryland	and and is m		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	ng Address	(Stree	t and Number	r or Rural	Route Numbe	r, City or Town,	State, Zip	Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee	nic, o				ess of Facility					
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/	a l		30. Name and address of person wh	o completed caus	e of death (Item 23a) (Type, F	Print)					0 0:		
5				A - 4.	NO 670	10	v. a	rar2	les st	100	420MV	Septemb	104	
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State of Maryland / Department of Health and Mental Hygien 25 per me, 8871,09/14/07dhb of Death

23a Pt II

Reg. No. 29564 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) August 26,2007 12:45 AM **Physician** Milton L. Schaum, Sr /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Middle River | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 7 | Nonth Ivy Hall Center 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 XM 2 ☐ F Yrs. 216-10-6416 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State ul Hygiene. . other than "natural", or Items 23a or 28a-f show vent, the Medical Examinar must be notified at 1 Tyes 2 No Perry Hall Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 4318 Blakely Avenue USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Gas & College (1-4or 5+) Contract Inspector Elementary/Secondary (0-12) Electric 12 18. Mother's Name (First, Middle, Maiden Sumame) tem 27 is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked ott Be Emma T. Schaum Louis Albert Schaum ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4318 Blakely Avenue-Perry Hall, MD 21236 Robert W. Schaum -son Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of 20a. Method of Disposition Competery, crematory or other place)
Parkwood Cemetery Aug. 29, 2007 Parkville, MD permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Qurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 8800 Harford Rd 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Parkville,MD 21234 andrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DChemic **Physician** /Medical Due to (or as a consequence of): **Examiner** CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760 attending physician Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetel death Year 1 Live birth Month Day þ in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0 the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. signed Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 DNo certificate 26. Place of Death Check on one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Landsing Home 5 Residence 6 Other (Specify) 1 XYes 2 € No 2 ER/Outpatient 3□ DOA Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of filled in by the funeral 27. Manner of Death After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after deatl Puneret Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 Homicide Lecritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. BASTERN BLVD WASBEN. MALIKA 82. Registrar's Signature 31. Date liled (Month, Day, Year) State 14 Registrar

DHMH 17 Rev 1/2001

Registrar

SEP 1 4 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0938M 07 ber /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner P 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1**X** M 2□F Nov.26 Director irainia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director YIOr 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ans bore یک 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenne Balto 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Balto Crematory or other pla Balto Crematory at Loudon 1 ☐ Burial 2 X Cremation 12007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOSEPH L. RUSS 2272 W. North 21. Signature of Funeral Service Licensee Ave. Balto. Md. 21 23a. Part / Enter the disease, or complications that othered the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HVS Immediate Cause (Final disease or condition **Physician** IZUVE disease or condition resulting in death) /Medical Due to (or as a consequence of). 3hrs Examiner Acidosis Diratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1∐ Yes To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 TYes 2 Accident 6 ☐ Could not be 3☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Funeral D 24 hours 1 • ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Memorial Hospital Maryland

30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) ,

Union

🏂. Registrar's Signature

ZOWIES. BARNES

1 4 2007

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

DOCTOR

ed (Month, Day, Year)

SEP 14

2007

32. Registrar's Signature

				For State Registrar	State of Ma	rylan		artmeı e <i>rtifica</i>							17	29568
		Physicia		1. Decedent's Name (First, Middle, L.								2. Date of De	eath			3. Time of Death
		/Medic	al	Anthony Benja 4a. Facility Name (If not institution, gi				45 035	. Taum a			Septem		12, 2 c. County o		12:25 p ^M
U		Examin	er	Stella Maris	ve street and number)				r, Town, or M oni U		or Death			Baltin		
		Funeral Director		220-07-7921	Sex 7. Age 87	(In yrs.	last birthday Yrs.	/) If Unde Months	er 1 Year Days	If Under Hours	Min	8. Date of Bir (Month, Da Feb. 2	th av. Year	ĺ920	9. Birthpl Count Mary	ace (State or Foreign and
	land	ow It		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or L	ocation							10	Od. Inside City Limits
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p.m.	ath w	s 23a nust b	era	2525 Pot Spring					21093		: :-0.0			USA	A	
	5-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. In portant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ender Armed Forces? 1 Yes 2 Note of the Yes, Give Year or Dates:	0	_	If Yes, spe		ispanic Or an, Mexica Specify:		cify Yes or No Rican, etc.))-	14. Race Black Specify:	, White, e	
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ĒM.	mor Pages	ent of ht: If it ny or o		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 37 ☐ Other (Spec		1	Place of Disp cemetery, cre aney				9/17	/07			-	ryland
EPTEMBER	Baltimore,	Departm In portai a y inju on e,		21. Signature of Juneral/Service Lice	angee /	1001		22. Name a				, , ,			-	k Road
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	//	/Medical Examiner		resulting in death)	a. Due to (or as a	conseq	uence of):		_						_	
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	68760, tifficate be exe	physici the bu	edical	d												
		70 00	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p			□Ectopic	Oregnancy			1.77.		23d. Date	of delive	•
(ecords, P.O. Box law requires that the death cert	y the att	Physician/M	In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute										Mon	th	Day Year
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NO		tificate or, pa		25. Was case referred to medical	ı					26 Place	of Doath	1 Yes Check only o	2 X IN		Yes	2 □ No
ANTHONY	or Vita Physician:	nis cer direct	To Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 🔯 inpatien	t 2 🗆	ER/Outpatie	ent 3 D	OA Othe			. 171		6 NOthe	(Specify	HOSPICE
•		n. After this certificate ha funeral director, page		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		28b. Time o Injury		28c. Injury Work	y at </td <td>28</td> <td>8d. Describe</td> <td></td> <td></td> <td></td> <td></td>	28	8d. Describe				
	DIVISION For Attending	death ctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be	De 280 Place of injur	v - At ho	ome, farm, st	M treet, factor	444	Yes 2□		8f. Location (Street a	and Numbe	or Rural	Route Number,
i	alor /	s affer	je di	4 ☐ Homicide determined	building, etc.	(Specif	y)	,			ļ	City or To	wn, Sta	te)	o, mara	riodio ridinosi,
	he Hospit		Medical (29a. Certifier (Check only one) 1	hysician: To the best of miner: On the basis of e and manner state	examina	wledge, dea tion and/or in	nth occurred	d at the tin	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(date a	(s) and mar nd place, a	ner as stand due to	ated. the cause(s)
	To th	To t	Ž	29b. Signature and title of certifier	/			29	c. License				29d. D	ate signed	(Month, L	Day, Year)
		7							11	37	25			7/12	10)
	10	+1		30. Name and address of person who DR. TARIQ MAHMOO					ф.	ΤΜΛΝΙΤ	TIM M	D 2109)3			
		Stat	е	31. Date filed (Month, Day, Year)	32. Registrar	's Signa	iture	A KU	M c	TINN	Oris F	m 2105	,,			
		Registra	ar	SFP14	2007	lesse	15	10004								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Dav Lie WICZ september /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore PKINS ttospital enns None 5. Social Security Number Year If Under 24 Hrs. . Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral №** M 2□ F Months Days Hours Min. 80 030 12 8375 Director Massachusetts March 6,1927 Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director 1 TYes 27 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? death with 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be to 3453 Nanmark Court 21042 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Yes, Give 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1945-46 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Doctor of Physical Chemistry 5+ JH Applied Physics Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental F George Dominic Satkiewicz Julia Markiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 L. Jeannette Satkiewicz/Wife 3453 Nanmark Court Ellicott City, MD 21042 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State Department of Important: If It any Injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gard, 9-15-2007 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. ature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician probable myocardia minutes disease or condition resulting in death) /Medical Due to (or as a consequence of); **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Year Day 5 ☐ Other (specify) P.0. ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 has certificate 2 No Physiclan: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 10 P 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident filled in by the 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 10/

Year)

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Date filed (Month, Day,

MD

32. Regis

's Signature

DHMH 17 Rev 1/2001

600 N Wolfe St B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sept. 10, ¤2007 James J. Smith, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veteran's Home Charlotte Hall St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. (Month Day, 1916) 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign West Virginia 91 216 05 5661 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 □Yes 2NNo St. Mary's Charlotte Hall 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Rd. 20622 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 17 Yes 2 No If Yes, Give Year or Dates:1944-46 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendant Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benson Smith Annie Dawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Smith, Jr./son 6130 Covington Rd. Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/14/2007 Metro Crematory Catonsville, MD 21. Signatura of uneral Service Lic 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. M01442 Pronis 4112 Old Columbia Pk. Ellicott City, MD 21043 23a. Part1 Enter the disease, or complications that caused the death. Do not en er the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition disease or condition resulting in death) Due to (or as con Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cones Due to (or as a co IF FEMALE 23d. Date of delivery 3 Ectopic pregnancy eath Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

and Mental Hygiene.

1 and 2 should be file Health and Mental H em 27 is marked oth

.. Pages 1 and

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra

Director

Funeral

þ

Completed

Be P MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ို

Physician/Medical þ Completed Be

23b. W

27. Manner of Deat

1 Natural 2 Accident

3 ☐ Suicide 4 Homicide

Medical Certification:

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar

as decedent pregnant	23c. If yes, outcome pt pregnanc
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the past 12 months? □Yes 2 □ No	4□Pregnant at time of deat
⊥Yes 2∐No	9 I Inknown

5 Pending investigation 6 ☐ Could not be

					20.	Flace of Dea	un (Un	eck unity uner		
Ho	ospital: 1 ☐ Inpatient	2 🗆] ER/Outpatient	3 □ D	OA Other: 4	Nursing H	ome	5 Residence	6 □Other (Specify)	
	28a. Date of Injury (Month, Day Y	ear)	28b. Time of Injury	М	28c. Injury at Work?	2 □ No	28d.	Describe how inju	ury occurred	
	28e. Place of injury building, etc. (- At h	ome, farm, stree fy)	t, facto	ry, office		28f. L	Location (Street a City or Town, Stat	und Number or Rural Route Numbe te)	r,
	Alama To Alam Innat of the		and a describer of a settle of		d. A. Alban, March, and	at a send of laws a	and the			

9/11/2007

(Check only	12 Certifying 2 Medical 8	g Physici Examiner	an: To the best of my knowledge, death occurrence on the basis of examination and/or investig	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus							
one)		2	and manner stated.								
29b. Signature and	title of certifier			29c. License number	29d. Date signed (Month, Day, Year)						

D0057574

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ahmed Heshmat Charlotte Hall Veteran's Home Charlotte Hall, MD 20622

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2304 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 7

		•	1- State of Maryland / De State of Maryland / De	epartment of Health and N Certificate of Death	⁄lental Hygie ^{Reg}			
10	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	ath	
	/Medic		James William Salter,	September	r 11, 2007 6:07	P^{M}		
	Examir	er	4a. Facility Name (If not institution, give street and number)		4c. County of Death			
		10	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Silver Spring (av) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Montgomery		
	Funeral Director		235-56-2916 1MM 2□ F 68 Yr.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 22,	9. Birthplace (State or Fo Country) 1939 Washington, D.C	n eigir	
			Usual Residence of Decedent		mpril 22,	1999 washington, Die		
	how		10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Li		
	89-f	cto	Maryland Montgomery Poto	mac		1 Yes 2	No No	
	vith th	Dire	10e. Street and Number	10f. Zip Code		. Citizen of What Country?		
	s 234	era	12101 Drews Court 11. Marital Status 12. Was Decedent Ever in U.S.	20854		ited States 14. Race - American Indian,		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Menial Hyglene. If item 27 is marked other than "natural", or items 23s or 28e-f show or other traumatic event, the Mexical Exacidinal means be incidited at	Completed by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married 2 Never Ma	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: White		
Maryland 21215-0036	2 hou	ted	15. Decedent's Education 16a. D	ecedent's Usual Occupation		b. Kind of Business/Industry		
215	P. Pan "n	ple	(Specify only highest grade completed) ((Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work e. DO NOT use retired)	ang			
21	od wil	Con		ttorney		Law		
nd	d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Sumame)		
χ	Men Men Marke Marke	10	James William Salter		Fellers			
Mar	12 sh h and 7 le m traum			ailing Address (Street and Number or Rui				
	1 and Health em 27 ther tr	- 3		Ol Drews Court, Pot	Data 200	y Land 20004 c. Location - City or Town, State		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		1 Burial 2 Commation 3 Removal from State	rematory or other place) Sept y Crematorium, Inc. 13,	ember			
臣	permit. Pag Department Important: I any injury o					ethesda, Maryland	_	
Ba	permit. Departrimports any inju		Mujuleles My XIVI 1101303	22 Name and Address of Facility Robert A. Pumphrey Fune: 300 West Montgomery Ave	nue, Rockvil	Le, Maryland 20850-280)5	
	Physician		23a. Part. Effer the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Myocardial In		or respiratory arrest	Approximate Interval Betwee Onset and Deal 6 Hours	ith	
1	/Medical Examiner		resulting in death) Due to (or as a consequence of)					
(E)	n. \$.	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Lung Cancer Due to (or as a consequence of)			1 Year		
	nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury					
Ć.	execu n and ial-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of)					
8760,	cate be executed physician and the burial-transit	cal	d					
9	ntifica ng ph	Physician/Medical	IF FEMALE:					
Вох	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of delivery Month Day Year	,	
-	the a	sici	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month Day 19a1		
P.0	that the de ted by the a detached t		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death	h?	
of Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ted by			1 □ Yes	2 ☐ No 3 ☐ Probably 4 💆 Unkr	nown	
ecc	has be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause	ilable e of	
= R	The The page	Con			performe 1 ☐ Yes 2 🖔	d? death? No 1 ☐ Yes 2 ☐ No		
/ita	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?		th (Check only one)			
of	Physi this c	은	1 Tyes 2 No Hospital: 1 Inpatient 2 M ER/Outp.			e 6 Other (Specify)		
u	Attending Physician: r death. sctor: After this certifice by the funeral director, p	i i	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 1 ☑Natural 5 ☐ Pending (Month, Day Year)		28d. Describe how	injury occurred		
Division	dea dea stor	lical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm		28f. Location (Stree	et and Number or Rural Route Number,		
Š	after Direct	Certification;	4 Homicide determined building, etc. (Specify)	, street, factory, office	City or Town, S		,	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 Medical Examiner: On the basis of examination and/one	eath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)		
	Fo the Mithin Complex	₹ E	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)		
	1			D62234	S	eptember 12, 2007		
29	11		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)				
0			Manish Agrawal, M.D. 9707 Medical	Center Drive, #300	, Rockvil	le, Maryland 20850	00	
P 100	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4 2007	Since the second				
-0 40	negisti	aı	SEPI 4 ZUU/ Justin Jo	A STATE OF THE STA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 11, 2007 **Physician** 4:31а м Gladys Elois Day Slade /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard 12105 Old Frederick Road Marriottsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 12 19 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2**X**☐ F 217-18-5678 Director 1910 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Howard 1 ☐ Yes 27 No Marriottsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1950 Mount View Rd. USA 21104 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event at a once. Bartgis Brothers Elementary/Secondary (0-12) College (1-4or 5+) payroll clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Amoss Ida Mae Shipley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1950 Mt. View Rd., Marriottsville, MD Calvin Day (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-14-07 Marriottsville, MD Mt. View Cemetery 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Box 195 Sykesville, MD 21784 P.O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Athero Elevotic Cardio Vascular Discorp Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year signed by the a d be detached for 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 97000 hu 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation ours after death.

leral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (MOHILII, Day, real)

D30641 September 112007

Fideath (Item 23a) (Type, Print)

Back River Neck Road Balhman Maylor

29d. Date signed (MOHILII, Day, real)

September 112007

All 2011

All 29b. Signature and title of certifier 4 Kamesh Jaba 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	1_	For State	State of	Marylan		irtment of F		and M		7 6	700	29573
	1.0	Registrar Decedent's Name (First, Middle	l set)		Cer	lilicate of	Deam		2. Date of Dea	-	301	3. Time of Death
Physician /Medical		Donald Wood	Thomas						Month	Day Der 13,	Year 2007	
Examiner	4 -	Facility Name (If not institution		*		4b. City, Town, o		f Death			y of Death	
	5.5	Ivy Hall Geri		er 7. Age (In yrs.	last birthdav)	If Under 1 Year	imore	24 Hrs.	8. Date of Birt	h	timore	
Funeral Director		214-26-6622	№ M 2□F	88	Yrs.	Months Days	Hours	Min.	(Month, Day 03/05/	7 1919		lace (State or Foreign try) Lucky
and w	-	ual Residence of Decedent State 10b. County		10c. City	y, Town or Lo	cation						0d. Inside City Limits
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be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Re Completed by Filmeral Director.		Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed For	^{2 □ No} WW	_	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 2 No		gin? (Spe i, Puerto F	city Yes or No- Rican, etc.)	Bla	ice - Americ ack, White, ify: Whi t	etc.
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d 2 should th and Mer 7 is marke traumatic	19	a. Informant's Name/Relations			1	ng Address (Street						Code)
1 and Health Health ther t		ancy Markowski a. Method of Disposition	(Niece)	20b. F	Place of Dispo	Level Rd	i		Lie, Mai	20c. Location		own. State
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permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau	21	. Signature of Funeral Service		0	22	2. Name and Addre				ci Fune:	ral H	ome P.A.
	23	John N.	Burkey	Mac Jused the deat	h Do not ent		Commercial				, Mar	yland 21221
Physician	Im	mock, or heart failure. List mediate Cause (Final	only one cause on ea	ach line.	4	Hustin	Gara.	<u>/</u>		ea.		Approximate Interval Between Onset and Death
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Examiner	_ Se	equentially list conditions,	b. ————————————————————————————————————									
executed in and ial-transit	ca Ca	equentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury at initiated events	300 to (1	of as a somely	derive Oly.							
	res	at initiated events sulting in death) Last	C. Due to (or as a conseq	uence of):							
physicia the bu	<u> </u>		d									-
attending p	IF 22	FEMALE: b. Was decedent pregnant	23c. If yes, out							23d. D	ate of deliv	erv
The law requires that the death certificate ate has been signed by the attending physoge 2 should be detached for use as the completed by Dhysician Madicinal and the business of the statement o	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of c wn		Ectopic pregnand Other (specify)	су				Month	Day Year
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w require sbeen signal	B	Fourte	Dok 1	ma,	\mathcal{L}^{ω}	01.1	1 1 1 C	1.	1 1 1	1	ear	bably 4 Hinknown
To the Hospital or Attending Physician: The law requivithin 24 hours after death. To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should Modical Contification: To Be Completed.		Shrete	Osreof	on on	, ,	MIN	ns no	Dan	24a. Was auto perfo		prior to co death?	opsy findings available impletion of cause of
sician certifi rector	25	. Was case referred to medica examiner? 1 ☐ Yes 2X No	Hospital:	25	150/0.4	Ot Ot	hor: e		(Check only o			
g Phys er this c		. Manner of Death	28a. Date (of Injury	28b. Time o					dence 6 🗆 O		fy)
ending sath. or: Aft he fun	<u> </u>	1 ☑Natural 5 ☐ Pendir investi	gation	h, Day Year)	Injury		Yes 2	No				
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To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, in Modical Contification: To Be Completely Contification:		(Check only 2 Medical	ng Physician: To the Examiner: On the ba	asis of examina	owledge, deat	h occurred at the	time, date ar opinion, dea	nd place, ath occurr	and due to the	cause(s) and r	manner as s	stated. to the cause(s)
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+ s + o		· Mar	M.D.			D.	-38	75	4	_		2007
lo+1	30	Name and address of person	who completed caus	e of death (Iter	n 23a) (Type,	Print))	21	221			, .
State	e 31	. Date filed (Month, Day, Year,	32.R	egistar's Sign	ature	Print) M.J						
Registra	r	2EL	+ + LUU/	MARKE SAL	1 10	JET TO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothy Mary Tasker September 9:55 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford County If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2ĂF 216-48-2401 Director 60 June 20,1947 Baltimore, MD. Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Edgewood 1 □Yes 2 No Maryland Harford County Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "netural", or items 23a or treumatic event, the Medical Examiner must be 1911 Bayberry Road 21040 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental H Be Adrian Henry Wiechert Lucy Rita Pellegrini ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Mr. Ronald Charles Tasker (Hus.) 1911 Bayberry Road Edgewood, Maryland 21040 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Sept. 13, 2007 1 Burial 2 Cremation 3 Removal from State = 5 Importent: If any injury or once, Forest Hill, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens eaceful Afternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 2, Timonium, Maryland 23a. Pard. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Obstavenus MADNIC YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that linitated events Due to (or as a consequence of) Examiner the burlal-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by PEATENSION 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death. 2 Accident filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours eft To the Funeral Di Tecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29c. License number 29b. Signato 0056296

Registrar

State

who completed cause of death (Item 23a) (Type, Print)

TOSON BINDAUM M.O. 500 Upor Cho 11. Date filed (Month, Day, Year) 32. Figistra's Signature

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			Registrar				Cei	tificate of	Death		Reg. N	.2001	23313
т	Physic	ian	Decedent's Name		,					2. Date of D	D	ay Year	3. Time of Death
	/Medi	cal			lyn Trav		e	45 Oit. T	-1	Sept.			3:20P M
0	Exami	ner			e street and number)		4b. City, Town, o		atn		c. County of Deat	
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ь	Director		214.44.	2501	1□M 2⊠E	61	Yrs.	Months Days	Hours Min	0. (Month, E	ay, Yea .19	46 00	hplace (State or Foreign untry) MD
	pu ,		Usual Residence of 10a. State			100 000	T						
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	ms 2: mus	Jera	11. Marital Status	int vic	tor Str	Ever in U.S	. 13. \	21225 Was Decedent of H f Yes, specify Cub;	lispanic Origin?	Specify Yes or N		14. Race - Ame	rican Indian,
9	or Ite	Ē	1 Never Marrie	ed 2 Mamied	Armed Forces 1 Yes 2 If Yes, Give	No.		. /		erto Rican, etc.)		Black, White	
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a	ld be ental ked c	To Be	Joseph T	ravagli	ne				Kay D	awson			
Maryland	shou and M s mar umat	-	19a. Informant's Na	me/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number or i	Rural Route Num	ber, City	or Town, State, 2	Zip Code)
	and 2 valth a 1 27 is		Doreath	a Jacob	s/compar	nion	3707	⁷ Saint	Victor	: St.,	Ba1	to., MD	21225
ore.	es 1 and file of He filter		20a. Method of Disp		Removal from State		ace of Dispo	sition (Name of natory or other place	ce)	Date	20c.	Location - City or	Town, State
<u>ä</u>	Pag ment ant: I		4 □ Donation	5 ☐ Other (Specif	fy)	[′] Ch	esape	ake Cre	em. 09.	11.07	Be	ltsvill	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medisal Examiner must be notified at once.		21. Signature of Fu	neral Service Lice	nsee M	0144	~>	. Name and Addre	. (remati	on .	And Fur	eral Balto
	<u>~~</u> = « •		de	la Mu	ultira	_						Pasture	s Dr. MD
В			shock, or hear	t failure. List only	plications that cause one cause on each	ed the death. line.	Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	-inai 1	a. CEREBRO			CCIDENT					
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		ē	Sequentially list con if any, leading to important cause. Enter Under Cause (Disease or ithat initiated events	ditions, mediate	b. Due to (or as	s a conseque	ence of):						
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6876	ate by hysic the bu	lical			d								
9 ×	death certificate l attending physic	Physician/Medic	IF FEMALE:		200 Huga autoom						- 1		
Вох	attence for us	ian	23b. Was decedent in the past 12 in	months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant	2 ☐ Fetal (death 3□	Ectopic pregnancy	У		Ì	23d. Date of del Month	ivery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 🔀 9 ☐ Unknown	No	9□Unknown	at time or de	au 5	Other (specify)					
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ta	slcian: The law certificate has b irector, page 2 s	BeC	25. Was case referr	ed to medical					26. Place of D	1 Yes eath (Check only		10 1 Tes	2 110
<u>^</u>	nysic nis ce I direc	To E	examiner? 1 ☐ Yes 2 聚 I	No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatien	t 3□ DOA Oth	er: 4 \(\sum \) Nursing	Home 5 ☐ Re	sidence	6XIOther (Spec	cify) HOSPICE
Division or Vital	ng P		 Manner of Death Matural 	l 5	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	e how inj	ury occurred	
sio	tendleath.	cati	2 ☐ Accident 3 ☐ Suicide	investigation					Yes 2 □ No				
Ν	or Attend after death Director: / I in by the f	Certification:	4 Homicide	determined	28e. Place of it	itc. (Specify)	ne, tarm, str	eet, factory, office		28f. Location City or T	(Street a own, Sta	and Number or Ru ite)	ıral Route Number,
_	the Hospital or Attending Physician: in 24 hours after death. the Funeral Director: After this certifical impletely filled in by the funeral director,	ပ္	29a. Certifier	1 Certifying Ph	nysician: To the bes	of my know	ledge, death	occurred at the tir	me date and pla	ce, and due to th	e cause	(s) and manner as	stated
	24 h 24 h e Fur letely	edical		2 Medical Exa	miner: On the basis and manner s	of examination	on and/or in	vestigation, in my o	opinion, death oc	curred at the time	e, date a	nd place, and due	to the cause(s)
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Me	29b. Signature and	title of certifier				29c, Licens	e number		29d. D	ate signed (Mont	h, Day, Year)
	1			~ (1-1			1)(437	25	d	-10-0	7
*	Y		30. Name and addre	ess of person who	completed cause of	death (Item 2	23a) (Type,	Print)					-
d			DR. TARIO	OOMHAM G	1 27			Y RD. T	IMONIUM	MD 210	93		
	。 Sta	ite	31. Date filed (Mont	SEP TI4	2007 32. Regist	trar's Signatu	ise	reach D					

			For State Registrar	State o	of Marylan		artmen rtificat			and M			007	29576
7	Physicia /Medic		1. Decedent's Name (First, Middle,	Last)	end				<u>.</u>		2. Date of Dea Month Septemb	Day	Year 2007	3. Time of Death 3:30AM M
	Examin	_	4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City,	Town, or	Location of	of Death	•	4c. Co	unty of Death	
(e 20)	3 22 - 1 - 12 - 12		626 Falmouth Co	urt 3. Sex	7 A== (/= +==	loot hirthdou	Syk If Under	esvi	11e	24 Hrs	8. Date of Birth		arroll	loop (Chate on Familia)
٥.	Funeral Director		213-64-1447	1. M 21√2 F	7. Age (In yrs. 53	Yrs.	Months	Days	Hours	Min.	(Month, Day	. Year)	Coun	lace (State or Foreign try) MD
	*		Usual Residence of Decedent								000. 2,	1900		
	how tat		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Ba-f s	Director	MD Carr	o11		Syke	svill							1 □ Yes 2√ No
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2-003	ral", o	b b	3 ☐ Widowed 4 🙀 Divorced	If Yes, G Year or I	Dates:		1 🗌 Yes	2 K J No	Specify:			Sp	ecify: Wh	nite
5	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent' (Specify only highest	s Education grade completed)	16a. Dece	dent's Usu kind of wo DO NOT us	al Occupa rk done d	ation during mos	t of worki	ing	16b. Kind	of Business/Ind	dustry
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Maryland	ges 1 and 2 should be to to Health and Mental If Item 27 is marked or or other traumatic eve	-	19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a			al Route Numbe		own, State, Zip	Code)
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altimore,	ges 1 at of He If Item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from	20b. F	Place of Dispo cemetery, cre	osition (Nar matory or c	ne of other plac	:e)		Date	20c. Locat	on - City or To	own, State
Ĕ	permit. Pages Department of I Important: If Ite any Injury or o		4 ☐ Donation 5 ☐ Other (Sp	ecify)		roll (1/07	Hamps	stead,	MD
Ball	pepart nport ny In		21. Signature of Funeral Service L	icensee	. 11-		2. Name ar							vn Road
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P.O. Box	atter d for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2 Feta gnant at time of c		⊒Ectopic p ⊒ Other <i>(s</i> j		/			200	Month	Day Year
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Division or	Phys r this ral dir	- To	1 Yes 2 No 27. Manner of Death	1 1	Inpatient 2 ☐ e of Injury	ER/Outpatie			4 🗆 N		me 5 Residence 1			fy)
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	To the Hospitallor Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ➤ Certifyin (Check only one)	g Physician: To the Examiner: On the	basis of examina	ation and/or i	nvestigatio	n, in my c	opinion, de	ath occur	red at the time,	date and pl	nd manner as s ace, and due t	stated. to the cause(s)
	o the ithin 2 or the or	Medical	29b. Signature and title of certifier	and ma	inner stated.		29	c. Licens	e number			29d. Date s	igned (Month,	Day, Year)
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/	27		30. Name and address freeson	who completed ca	/1 ~	m 23a) (Type	, Print)	24 9	Sut	310	Ann	ادام	MD	21401
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	Regist	rar	SEP 1 4	2007		~ /								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year 200 september /Medical Wis Wathins 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balt Samare Se dal Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number last birthday **Funeral** Months Days Hours 9.66. 1**X**1M 2□ F Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director mnBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4351 Hicholas venu. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify. 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) echanic Fix Bik Baltimore, Maryland 21 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Wathins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MO +351 Nicholas nda Wat Kins/ Aue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 Removal from State Thing Memorial Park 09.19.2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio, niee 22. Name and Address of Facility Vaughn C. Greene funred Service C Vaush 728 Liberty And Thordallotain MO 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or a a consequence of) that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 X Yes 2 No 3 Probably 4 Unknown been sign Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has 21X No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ⊠İnpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

in 9000 Franklin 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIN

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 28t per me 98/1,09/14/07thb
State of Maryland / Department of Health and Mental Hygienes a page 17 Amend Item 22d per me est U9/14/0/dnb State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 WATERS **Physician** ICHARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health & Kehab ummit Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at M 1 Yes 2 No Daltimor **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be n USK 14. Race - American Indian 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 110 3altimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) abore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot 2 19b. Mailing Address (Street and Number or Reral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health item 27 i other 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (CVD) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last TON APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and the burial-trar CERTIFICA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached to 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28d. Describe how injury occurred
Subject driver of car collided with 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Injury 5 Pending investigation 8:50 P M 1 ☐ Yes 2X No 04/04/2007 2 Accident Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Interstate 95 near determined 4 Homicide Roadway Caton Avenue, Baltimore, MD 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 036942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) derick Rp. Coforgrille, ND 21228 TURAKAIA My 1009 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 1 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 107 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7, 2007 6:52 PM /Medical <u>James Herbert Wilson,Jr.</u> otember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Macuano Social Security Number Battimure CH Under 1 Year | If Under 24 Hrs. nenera 8. Date of Birth (Month, Day, Year) 08-14-1957 50 (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours MARYTand Yrs. Director 220.66.1408 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 521 Thornfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Han and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Wilson, Sr. Ora Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thornfield Rd. Baltimore, MD 21229 Ora Wilson/mother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. Date 20c. Location - City or Town, State 09.10.07 Beltsville, MD 4 Donation 5 Dother (Specify) ^{22. Name and Address of Facility}Cremation And Funeral Balto Alternatives 8717 Green Pastures Dr. MD 21. Signature of Funeral Service Licensee Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Immediate Cause (Final disease or condition resulting in death) Physician SSIVC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed J physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐Yes 2☐No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physiclan: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 npatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Tabatabae

SEP 1 4 2007

31. Date filed (Month, Day, Year)

Maryland General

90

3. Registrar's Signature

m.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9 na /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and ne 4b. City, Town, or Location of Death Examiner The more of the lift Under 24 Hrs. rive 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 1 F Maryland 50-077 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other thaumatic event, the Medical Examiner must be notified, at 1 🕅 Yes 2 🗆 No Director timor Apt 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ 3 ☐ Widowed 4 ☐ Divorced lac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19 ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 2007 000 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signatore of Funeral Service Licensee 22. Name and Address of Fa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mon-WS Immediate Cause (Final disease or condition resulting in death) Physician Metastatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cun to for as a consequence of Examiner and burial-trar Due to (or as a consequence of): neral **Director:** A ler this certificate has been signed by the attending physician filled in by the fu neral director, page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 3∏ DOA Certification: To 1 Inpatient 2 ER/Outpatient 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours a er death. To the Funeral Director: A er this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

State Registrar

31. Date filed (Month, Day, Year) 4 2007

29b. Signature and title of certifier

Con

HOSPICE 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

838 N. Eutaw St

29c. License number

Baltimore

29d. Date signed (Month, Day, Year)

ptember 11, 2007

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 29582 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST 27, 2007 ELIZA ADAMS 12:53 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12 BANNINGTON DRIVE KETTERING PRINCE GEORGES 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Months Days Hours SOUTH CAROLINA JUNE 6. 1911 Director 96 249-17-7560 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MARYLAND PRINCE GEORGES KETTERING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 12 BANNINGTON DRIVE 20774 UNITED STATES "natural", or Items 23a dical Examiner must t Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Specify Specify: BLACK ģ 3 Widowed 4 □ Divorced Completed 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be JACOB MONROE JACKSON ENDIA MACKEY JACKSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum once. ELIZA DELLERS/DAUGHTER 12 BANNINGTON DRIVE, KETTERING, MARYLAND 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MT. CANAAN CH. CEM. SEPT. 8, 2007 TRENTON, SOUTH CAROLINA 4 □ Donation 5 □ Other (Specify) THORNTON FUNERAL HOME, P.A.

22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician FAILURE TO THRIVE months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SENILE DEMENTIA Years Sequentially list conditions, if any bound of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Dav 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform certificate 20 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27 No 1 | Inpatient 2 ER/Outpatient 3 DOA ို this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending (Month, Day Year) 5 Pending within 24 hours are. To the Funeral Director: / investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 7500 Greenway Ctr Dr. Greenbelt, MO 20770 Schooler MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 1

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Year Keith K. Abbott 08 2007 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kegional Medical Center MICEMICA reninsula Palisbure If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**⊠**M 2□F Director 362-30-1939 75 Michigan Sept. 2, 1931 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 East Elizabeth Street 21875 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1½Yes 2 No 1950− If Yes, Give Year or Dates: 1953 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brakeman 12 Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Abbott 2 Ilah Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 E. Elizabeth Street Delmar, MD Shirley T. Abbott (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 8-29-2007 Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home
13 E. Grove St. Delmar, DE 21. Signature of Funeral Service Licensee jourel 23a. Part1. Enter the c sease, or conshock, or heart follure. List only that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGE STI VE FAILURG **Physician** /Medical Due to (or as a consequence of): Examiner 10 RONARY DI 50035 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed CARDIOMYOFATHY Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown signed by the best of the signal of the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. To the Hospital or Attending Physical and Physical 24 hours after death.

To the Funeral Director: After this of

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's Signature

SWIERKOSZ

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

100 E. CARROLL STREET SALISBURY Md 21801

29d. Date signed (Month, Day, Year) 08/28/2007

			State of Maryland / Department of Health and Mental Hygiene 2007 2958 1- State Registra MEND#1perMD, 8/30/07, BW, Moo Certificate of Death 1. Decedent's Name (First, Middle, Last) Donis Finora Apperson 2. Date of Death 3. Time of Death 3. Time of Death
	×.		Month Day Year
¥	Physicia /Medic	an	Poris Elegnona Apperson Aug 24, 2007 21001
jā.	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death
6	Funeral		To An Jones In Service In the Indian
T.	Director		213-16-2846 1 M 2 XF 89 Yrs. Months Days Hours Min. Jan. 19, 1918 Mary Land
	nd w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit
	Maryla f sho led at	tor	Maryland Prince George's Beltsville
	n the r. 28a-	irec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ath wit 23a c ust be	ralD	4412 W. Caroline Avenue 20705 United States 13 Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Bace - American Indian,
36	be filed within 72 hours after death with the Maryland Hygiene. In the With the "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Married 3 Widowed 4 Divorced 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Hace - American Indian, Black, White, etc. 15. Yes, specify Yes or No-lif Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 16. Hace - American Indian, Black, White, etc. 17. Yes 2 No Specify: 18. Hace - American Indian, Black, White, etc. 19. Yes, specify Yes or No-lif Yes, specify Yes or No-lif Yes, specify Cuban, Mexican, Puerlo Rican, Puerlo Rican, etc.)
9	2 hou latura ical E	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
21	within 7 iene. than "r the Med	mple	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home
22	filed w Hygiei other ti	S	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
auc	d be f ental k ked of c eve	To Be	Sidney M. Franklin Katie May Sandy
	nd 2 should be alth and Mental 27 Is marked o r traumatic eve	ř	19a. Informant's Name/Relationship (Type. Print) Joyce K. Apperson -daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 Telegraph Road, Lot 40 Severn, Maryland 21144
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA Level V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland2070
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.
	Physician		Immediate Cause (Final disease or condition a. Ventricular Fibrillation hours
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Azute Myocardial Infanction Due to (or as a consequence of): Azute Myocardial Infanction Due to (or as a consequence of):
		ē	b. Azute Myocavolial Witzurchen if any, leading to immediate Due to (or as a consequence of):
	cuted id ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.
Ö,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):
8760,	cate b	dical	d
ဖ	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the bural-transit	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery
Box	death atter d for u	iciar	23b. Was decedent pregnant in the past 12 pronths? 1
0	ires that the de signed by the a be detached i	hys	9 Unknown
	es tha igned be de	by F	
ord	w require been si should b		
Sec	has b	Completed	24a. Was an autopsy findings availe prior to complete or death?
Vital Records,			
Š	Physician: this certific ral director,	To Be	examiner? Hospital: Other:
n or	ding Ph n. After th funeral		
Division	Attending r death. ector: After by the fune	catic	2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Ξ̈́	or At ther d	Certification:	3 Suicide 4 Homicide Suicide 4 Homicide Suicide Suicide 4 Homicide Suicide Sui
_	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	o the vithin i	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			1 Hudian MD 142892 Aug 24 2007
(P		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
			29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aug 24 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis Muidian 10724 Liffle Patnxent Pankway Columbia MP 21 31. Date filed (Month, Day, Year) AUG 30 2007 32 Segistrar's Signature AUG 30 2007
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3 0 2007
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 5 2007 Physician 4:30 aM BESSIE VIRGINIA ATKINSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 11958 Kennedyville Rd. Kennedyville Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 3 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Min. Days Hours 1916 DElaware 1 □ M 2 🔀 F 91 Yrs 221-10-8774 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 X Yes 2 □ No "natural", or items 23a or 28a-f sh idical Examiner must be notified Director Kennedyville MD Kent 10g. Citizen of What Country? 10e. Street and Number 11958 Kennedyville Rd. 21645 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 <u>Ş</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Desk Clerk Housekeeper Motel 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Reed Emma Stubbs 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John C. Atkinson (husband) P.O. Box 154 Kennedyville, MD, 21645 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 9/8/07 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) neral Service Li ensee 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 М00510 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deat Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE . esn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 ☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2☐NO 3☐ Probably 4☐Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has b irector, page 2 sl autopsy performed 1□ Yes 2 INo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ After this Mann of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation within 24 hours after upage...

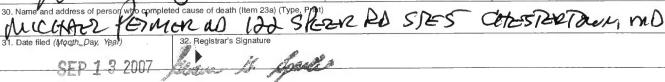
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

State

Registrar

31. Date filed (Month, Day,

29b. Signature



ORIGINAL

29c. License number

0060301

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ()9 **Physician** 08 2007 0415 DOROTHY AMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1□ M 2□ Hours Dec 27. 1921 Director 212-24-0316 85 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at Allegany Cumberland 1, Yes 2 No MD **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 512 Winfred Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XIO Specify. è 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Emma L. Emerick Bower ည William A. Bower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21560 P.O. Box 12 Spring Gap Douglas Aman son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/2007 Scarpelli Funeral Home, P.A. MD Cresaptown 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line.

Immer ate Cause (Final disea For condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed es 2 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 ☐ Accident 5 Pending investigation (Month, Day Year) 1 ∏Yes 2 ∏No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide the Hospital X Certifying Physician: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36766

State Registrar

DHMH 17 Rev 1/2001

DRIVE, Comberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

rooma

31. Date filed (Month, Day, Year) SEP 1 3 2007

		٠	1 - For State of Maryland / D	-		f Health a of Death			ene 9. N 2 0 0	7 29587
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Charles Aldridge, Jr.					2. Date of Death Month Sept		3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number) 6702 Bobtown Road			n, or Location of	of Death		4c. County of Dorch	Death ester
	Funeral Director		5. Social Security Number 214.30.8510 6. Sex 1 PM 2 F 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 7. Age (In yrs. last birth 1. Age (In yrs. last	rday). 'rs.	If Under 1 Ye Months Da	ear If Under ays Hours	24 Hrs. Min.	8. Date of Birth Month, Day, NOV. 1	5°,1933	Birthplace (State or Foreign Country) Maryland
	show	j.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Dorchester		cation rlock					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the N a or 28a-f	Director	10e. Street and Number 6702 Robtown Rd		10f. Zip Coo	de 21643		10	g. Citizen of Wha	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-1 show patical Examinations! be retitined at	by Funeral	If Yes. Give		Vas Decedent f Yes, specify C	,		ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc. Black
21215-0036	d within 72 hour piene. r than "natural"	Completed b		(Give life. L	dent's Usual Ockind of work do DO NOT use re aborer	one during mos stired)	t of workii	ng	6b. Kind of Busine	
land 2	be filed tal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Charles Aldridge, Sr.					(First, Middle, M		
Maryland	nd 2 should be the and Mental 27 is marked r traumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b.			reet and Number	er or Rura		City or Town, Star	re, <i>Zip Code)</i> 21643
Baltimore,	ages 1 and ent of Healt of Healt of Your other you other		20a. Method of Disposition 1 Surface of Unity State 1 Other (Specify) 20b. Place of Unity State 20b. Place of Unity State 20c. Place , cren	sition (Name of natory or other ure Ce	place)			Dc. Location - City		
Balti	permit. Page Department Important: If any injury o		21 Agnature of Funeral Service License 2	S	Pannand Ad	Box	ĕşa1	Home Federa	PpA lsburg,	² 16 N ₁ Mai ⁿ
100	Fnysician		29a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	-			cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		HOGAN L.T. B.	lee	ely					10 days
8,0928	cate be executed obysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Cause Ca):	ith,	Pertol	hyp	perfusia	ù	172
.O. Box 687	ne death certifing the attending the deferuse as	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown d. 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregna Other (specify,				23d. Date of Month	delivery Day Year
a	quires that the nation of signed by and be detacted	þ	Part II. Other significant conditions contributing to death but not resulting in the State of Mc of Column	he un	derlying cause	given in Part I.		23e. Did toba		e to the cause of death?
Vital Records,		Completed						24a. Was an autopsy performe	prior	
	Physician: The lar this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient	: 3□ DOA	26. Place Other: 4 ☐ Nu		(Check only one)	ce 6 □Other (S	ipecify)
Division of	or Attending Phater death. Director: After this in by the funeral	ertification;	27. Manner of Death 1	ne of ury	28c. Ir	njury at Work? I □ Yes 2 □ I	2	8d. Describe how	injury occurred	
Divis	tal or Atters after de safter de al Directo	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, stre	et, factory, office	се	2	8f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) **Tertifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death or inv	occurred at the estigation, in m	e time, date and ny opinion, deat	d place, a th occurre	nd due to the cau d at the time, date	se(s) and manner and place, and	r as stated. due to the cause(s)
l	To the within 2 To the complet	Σ	29b. Signature and title of certifier Moderate and title of certifier When the control of the		1	ense number	-8	1	Date signed (Mi	
	2		30. Name and address of person who completed cause of death (Item 23a) (The Michael Packetus No. 307 (ype, F	Print) Heis	Huri	lock	nd o	40f 4 216 43	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 3 2007	103	ale,			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 10:00att William Michael Bailey Sr. 8/27/2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2607 Chapel Lake Dr. Apt. 414 Gambrills Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Months Hours 1 ☑ M 2 ☐ F 60 1071971946 Yrs Maryland Director 216-42-5406 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 1 ☐ Yes StarNo notified MD Director Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be 2607 Chapel Lake Dr. 238 Apt. 414 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No 1963— If Yes, Give Year or Dates: 1968 1 Never Married 2 Married 10 White 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4X Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Tech DOD 7 is marked other traumatic event, t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Bailey Mary C. Kuzma ဂ္ 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Michael Bailey Jr. Son 28242 Forrest Landing Rd. Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 8/31/2007 Annapolis, MD 4□Donation 5 Dott (Specifyentombment 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral St vice Licensee 12 Ridgely Ave. Annapolis, MD 21401 . Fart . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ho k, or hear failule. List only one cause on each line. Imm+dian Cause (Final dise ser r condition result in in death) Physician Earc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 dunknown 1 ∏ Yes 2 ∏ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy te ha performe 672 KYS162 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2<mark>⊡</mark> No Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 1 atural 5 Pending investigation s after decral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

within 24 hours a completely State

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month

MB ho comple ed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner a

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 10:30 A M Aug 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 303 Gordon Avenue Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1**⊠** M 2□ F 60 577-64-1228 Director Mar 22, 1947 Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Director MD Severna Park 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Gordon Avenue 21146 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1X)Yes 2□No IfYes, Give Year or Dates:Vietnam 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Beverage Company permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important; If item 27 is marked other I any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel L. Brown Martha Murray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane D. Brown/ Wife 303 Gordon Avenue, Severna Park, MD 21146 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State August 28, MD Veterans Cemetery Crownsville, MD 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner W Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. | the detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy perform certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 ☐ Pending investigation Hospital or Attending 1 ☐ Yes 2 ☐ No death. hours after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 ☐ Homicide filled in within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature

Registrar

State

Name a

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** John William Becker August 30, 2007 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director 82 220 14 5023 29, 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show Iner must be notified at 1 ☐Yes 2 ☐No Director MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10078 Carillon Dr. 21042 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 EYes 2 No 1945
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1943 altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Principal Howard County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Becker Clara Alice Wood 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol M. Myers/Daughter 10078 Carillon Dr. Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 9/4/2007 Ellicott City, MD 4 Donation 5 Other (Specify) M01442 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licens 4112 Old Columbia Pk. Ellicott City, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ONE DAV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, by Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CORONARY ARTERY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Per (Specify) 1 Yes P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Matural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MD 6565 NI CHARLES ST, SUITE 216, BALTIMORE, MD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2007 Registrar

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August 20, 2007 Georgia Baptie Martha /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🛛 F 569-36-1660 85 Nov. 13,1921 California Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 TyYes 2 □ No Director Gaithersburg Maryland Montgomery 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number #107 20877 United States 407 Russell Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: Caucasian 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony G. Papadakis Ipheginia Tambacopoulis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Berger / Daughter Brattle Court, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 8/28/2007 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List grily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease er ondition resulting in death) Physician Ovarian Cancer 9 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bis-ass or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed attending physician and use as the burial-trai Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 perform 1□ Yes 2X No certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After or Attending 5 Pending Injury 1 X Natural 1 ☐ Yes 2 ☐ No investigation nours after death.

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filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joseph M. Hazzerty MD D32407 August 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, Rockville, Maryland 20850 M.D. Joseph M. Haggerty, 31. Date filed (Month, Day, Year) gistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

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Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 ^{Year} Day **Physician** August 25, 8:15 A Bowe Eugene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 12918 Ottawa Iusby
If Under 1 Year | If Under 24 Hrs. Calvert Drive 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 ☐ F Yrs 1938 Virginia 8, Director 229-48-3270 68 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXVo Calvert Lusby MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20657 U.S.A. 12918 Ottawa Drive by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2XXMarried 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Apartment management 9 maintenance engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Blanche Bowe** ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20657 12918 Ottawa Drive, Lusby, MD Delores Bowe, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Memorial Garden 08/30/2007 Charlottesville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Lightsee 20 American Lane, Lusby, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** 8 months disease or condition resulting in death) pulmonary adencarcinoma /Medical Due to (or as a consequence of): **Examiner** COPD Sequentially list conditions, if any, leading to immediate cause. Error underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? החופו תווא כפתתווכמte has been signed i funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 1∐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2008 1100 FIRST WAShi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

3 2007

			1 - For State Registrar	State of Maryland / D	Department of Certificate of	Health and Death	Reg.	ne No. 2007	29595
, in	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Margaret Ann Blaze An Blaze An Blaze An Blaze An Blaze		4b City Town	or Location of Deat	2. Date of Death Month	Day Year 30 2007 4c. County of Death	3. Time of Death
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	ith the Man or 28a-f sh	Director	Maryland Dorcheste	er Cambrio	dge 101. Zip Code		10g.	Citizen of What Cou	1X Yes 2 □ No intry?
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Maryland 21215-0036	wilhin 72 hour ane. then "natural	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: ation completed) College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin Teacher	during most of wor	rking	b. Kind of Business/Ir	
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	1 and Health em 27 ther tr		Rose Marie Walsh/Si 20a. Method of Disposition	ster P. (Mailing Address (Stree D. Box 8, C Disposition (Name of y, crematory or other pla	hurch Hil	1, MD 2162		
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 2 Signature of Fungray Service Licenser	Dorches	ster Memori	al Park 9	/1/2007 Ca	ambride,	MD
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ras, r	w requires that the de been signed by the should be deteched	Ď	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause g	ven in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
VITAL Mecord	as b	Completed					24a. Was an autopsy performed 1 ☐ Yes 🏖 🛱	prior to co death?	opsy findings available impletion of cause of
ION OF VIE	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: Atter this certificate he completely filled in by the funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Ti	ime of 28c. Injury Wo	her: 4 🗆 Nursing H	th Check only one) ome 5 Residence 28d. Describe how in		(y)
DIVISION	pital or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fambuilding, etc. (Specify)			28f. Location (Street City or Town, St	tate)	
	Fo the Hosi within 24 ho Fo the Fun completely f	Medical	29a. Certifier (Check only one) 2□ Medical Examine 29b. Signature and title of certifier	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the ti for investigation, in my 29c. Licens	opinion, death occu	rred at the time, date	e(s) and manner as s and place, and due t Date signed (Month,	o the cause(s)
			30. Name and andress of person who corr	pleted cause of death (Item 23a) (1	Type, Print)	6388	Her lock		
Ì	\S Sta Registr		Michael T Pi	32. Registrar's Signatur	302, Collin	us Ave	Her lock	e Mel Di	643

State of Maryland / Department of Health and Mental Hygiene $\,2\,0\,0\,7\,$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician JERRY** 4:23 A M BECKNER 08 31 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 62 Director 233-70-6563 8-21-1945 WV Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Director WV HARDY OLD FIELDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 274 TANGLEWOOD DRIVE 26845 USA Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene.
unt: If Item 27 Is marked other than "natural", or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT JAMES BECKNER CLARA SMITH BECKNER ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA K. BECKNER 274 TANGLEWOOD DRIVE OLD FIELDS 26845(wv) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 9 - 3 - 07MOUNT UNION CEMETERY 4 Donation 5 Other (Specify) MOUNT UNION, 22. Name and Address of Facility 21. Signatur of Fur eral Se FUNERAL ELMORE HOME MOOREFIELD WV Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** May 2005) disease or condition Due to (or as a consequence of) resulting in death) /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (under a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has t autopsy page certificate 1□ Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Injury 1 Natural 1 TYes 2 TNo 2 ☐ Accident within 24 hours after death To the Funeral Director: death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 200 / 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenul Cumberland Maryland amar Zaman MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Corbin ivex /Medical a. Fecility Name (If not institution, give street and number) City, Town, or Location of Death Examiner 7. Marys Mome 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1**X** M 2□ F 84 579-14-1358 10. 1923 Virginia Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other then "natural", or items 23s or 28s-f show sumatic event, the Medical Exampler must be positived at Maryland Charles La Plata 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11502 Deer Lane 20646 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1★1Yes 2□No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify à 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working) life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Government Electrician Ŕ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Lee Grimes George E. Corbin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Smith - Daughter 11502 Deer Lane, La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
eny Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans' Cemetery 9-6-2007 4 □ Donation 5 □ Other (Specify) Cheltenham, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M01246 Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as Physician/Medical Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a conseque Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1□ Yes 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ဥ 1 Yes 2 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: A 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D0057574 August 31, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 176 Ahmed Heshmat, MD, 10810 Connecticut Avenue, Kensington, MD 20895 32. Raistrar's Signature 31. Date filed (Month, Day, Year) AUG 3 State 1 2007 Registrar

Re	eg. No.	2007	295	M (7)
Date of Deat Month	h Dav	Year	3. Time of Deal	70
August	,		1:20 ^p	M
	4c. C	ounty of Death		

Montgomery

578-28-8173 81 Usual Residence of Decedent

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Oct. 31, 1925 New York

10a. State 10b. County Directo

Maryland

death with the Maryland

r 28a-f show notified at

Funeral

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Completed

Be

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Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re-

e filed within 72 hours after il Hygiene. other than "natural", or ite

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If I lem 27 is marked othany Injury or other traumatic event

Physician

/Medical

Examiner

and the burial-trar

attending physician for use as the buria

be exec

Division or Vital Records. P.O. Box 68760.

Baltimore, Maryland 21215-0036

b

10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Wheaton

Montgomery 10e. Street and Number 12804 Crisfield Road

10f. Zip Code 10g. Citizen of What Country? 20906 USA

14. Race - American Indian, Black, White, etc.

11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify.

SpecWhite 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Public Elementary School

17. Father's Name (First, Middle, Last) Samuel V. Frank

18. Mother's Name (First, Middle, Maiden Surname) Anna S. Lukas

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Randy George Changuris/Son

2815 Rohrersville Road, Brownsville, MD 21715

20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park

Teacher

Date 20c. Location - City or Town, State August 31 2007 Rockville, Maryland

4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee

Francis J. Collins Funeral Home Inc.

500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final resulting in death)

Acute Myocardial Infarction Due to (or as a consequence of):

days

Year

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last

Congestive Heart Failure

days

Chronic Renal Failure

days

Due to (or as a consequence of):

23b. Was decedent pregnant

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death

3 Ectopic pregnancy

23d. Date of delivery Month

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

4☐Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2X No 27. Manner of Death

1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

mo

29a, Certifier (Check only one)

1 X Natural

2 Accident

Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gailhers brug

apature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

29c. License number

29d. Date signed (Month, Day, Year)

State

Registra

al or Attend s after death.

within 24 hours
the Funeral D

AHMED 31. Date filed (Month, Day, Year)
AUG 3 0 2007 40 83819 BOX

		1 - State Registrar		/land / Depa Ce	rtificate of		R	_{eg. No.} 200	
Physici /Medi Examir	cal	Decedent's Name (First, Middle, La Virginia Mar 4a. Facility Name (If not institution, giv	ie Chandle	er	4b. City, Town, c	r Location of Death	_	Day Year 23, 2007 4c. County of De	2:06 p
		Washington Adve		cal n yrs. last birthday)	Takoma If Under 1 Year	Park If Under 24 Hrs.	8. Date of Birth	Montgom	ery
uneral irector			7.5	56 Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 16		irthplace (State or Fore Country) W York
-f show	tor	10a. State 10b. County MD Calve		oc. City, Town or Lo					10d. Inside City Lim 1 ☐ Yes 2 🔀
or 28a	Director	10e. Street and Number		50101	10f. Zip Code		1	0g. Citizen of What 0	Country?
238		724 Runabout L			2068			U.S.A.	
rthen "netural", or Iteme 23a or 28a-f ehow Ira Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of HIFYes, specify Cub. 1 ☐ Yes 2 X No		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
Madical J	Completed	15. Decedent's E. (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Busines	ss/Industry
1	E O		4	Regi	stered Nu	ırse		Health Ca	are
event, II	Be (17. Father's Name (First, Middle, Last,				18. Mother's Nan	ne (First, Middle, I	Maiden Sumame)	
markad o	2	Hugh Elvet	Lewis			Marie	Elizabe		11ivan
		19a. Informant's Name/Relationship (Туре, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number	City or Town, State,	, Zip Code)
Item 27 i		Dennis M. Chandle		724	Runabout	Loop, So		MD 20688	
if Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre		1		20c. Location - City of	
ury		4 ☐ Donation 5 ☐ Other (Specif	y)	St. John	Vianney	Cem. 08/	27/07 P	rince Fre	derick, M
Important: If Ite		Sur alure of Funeral Service Licer	Jula	1	2. Name and Addre			neral Home D 20657	e, P.A.
/sician		23a. Part . Enter the disease, or com shock, or heart failure. List onty Immediate Cause (Final disease or condition	one cause on each line.				or respiratory arre	∍st,	Approximate Interval Between Onset and Death
ledical aminer		resulting in death)	Due to (or as a co	rstem org	an Tallur	<u>re</u>			1 day
	er	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury	b. Sensis	onsequence of):					Joay
ysician and le burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. MSSA en	docardit	is				3 days
	×	resulting in death) Last							
physician the buria	cai	resulting in death) Last	d						
attending phi for use as th	cai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ☑ Vo 9 ☐ Unknown		Fetal death 3	□Ectopic pregnanc	,		23d. Date of d Month	lelivery Day Year
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ate has been signed by the attending ph page 2 should be detached for use as th	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of mitral valve presented to medical examiner?	23c. If yes, outcome of particles of the second of the sec	Fetal death 35 e of death 55	□ Other (specify)	en in Part I. 26. Place of Dea	1 Yes 24a. Was a autops perforr 1 Yes 2	Month pacco use contribute as 2 No 3 f	Day Year to the cause of death Probably 4 □Unkni autopsy findings availa completion of cause Probable 2 □ No
this certificate has been signed by the attending ph al director, page 2 should be detached for use as th	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of mitral valve present the valve present the present the valve pres	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown contributing to death but n	Fetal death 35 e of death 55 or resulting in the u	Other (specify)	en in Part I. 26. Place of Dea er: 4 Nursing H	24a. Was a autops perform 1 Yes 24th (Check only onlone 5 Reside	Month pacco use contribute as 2 No 3 prior to death? 1 Ye e) nncc 6 Other (Sp	Day Year to the cause of death Probably 4 Unkn autopsy findings avail o completion of cause es 2 No
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Director: After this certificate has been signed by the attending phin by the tuneral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of particles of the second of the sec	Fetal death 3 [e of death 5 [ot resulting in the u 2 ER/Outpatier 28b. Time o Injury At home, farm, st	Other (specify) Inderlying cause give Int 3 DOA Other Sec. Injury M 1 1	en in Part I. 26. Place of Dea er: 4 □ Nursing H	24a. Was a autops perforr 1 Yes 2 atth (Check only on ome 5 Reside 28d. Describe ho	Month pacco use contribute as 2 X No 3 F prior to death? 1 Ye poince 6 Other (Sp w injury occurred	Day Year to the cause of death Probably 4 □Unkni autopsy findings availa completion of cause Probable 2 □ No
Director: After this certificate has been signed by the attending phin by the tuneral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown contributing to death but not colapse Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye) 28e. Place of Injury	Petal death 35 e of death 55 or resulting in the use of death 55 o	Other (specify) Inderlying cause given the state of the	26. Place of Dea er: 4 \(\text{Nursing H} \) yat k? Yes 2 \(\text{No} \)	24a. Was a autops perform 1 Yes 2 ath (Check only on ome 5 Reside 28d. Describe hours of the city or Town and due to the capable 28d. and due to the capable 28d. And the city or Town and due to the capable 28d.	Month pacco use contribute as 2 No 3 f prior to death? 1 Ye e) prior to death? 2 Ye e) prior to death? 1 Ye e) prior to death? 2 Ye e) prior to death?	Day Year to the cause of death Probably 4 Unkni autopsy findings avail o completion of cause es 2 No Decify) Rural Route Number, as stated.
Director: After this certificate has been signed by the attending phin by the tuneral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of particles of the	Petal death 35 e of death 55 or resulting in the use of death 55 o	Other (specify) Inderlying cause given the state of the	en in Part I. 26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No me, date and place pinion, death occu	24a. Was a autops perform 1 Yes 2 atth (Check only on tome 5 Reside 28d. Describe how 28d. Location (St. City or Town), and due to the carried at the time, do	Month pacco use contribute as 2 No 3 f prior to death? 1 Ye e) prior to death? 2 Ye e) prior to death? 1 Ye e) prior to death? 2 Ye e) prior to death?	Day Year to the cause of death' Probably 4 Unknot autopsy findings available ocompletion of cause? Probably 4 Decify) Rural Route Number, as stated. use to the cause(s)
certificate has been signed by the attending phrector, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of particles of the	Petal death 35 e of death 55 or resulting in the use of death 55 o	other (specify) Inderlying cause give Int 3 DOA Other Section 28c. Injury Wor 1 Freet, factory, office the occurred at the tire vestigation, in my continuous c	en in Part I. 26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No me, date and place pinion, death occu	24a. Was a autops perform 1 Yes 2 atth (Check only on tome 5 Reside 28d. Describe how 28d. Location (St. City or Town), and due to the carried at the time, do	Month Dacco use contribute as 2 No 3 F no 24b. Were a prior to death? 1 Ye Proce 6 Other (Sp ow injury occurred Ausse(s) and manner a ate and place, and di	Day Year to the cause of death Probably 4 Unknown autopsy findings available ocompletion of cause ess 2 No Decify) Rural Route Number, as stated, use to the cause(s)
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	hysici /Medic	al	1. Decedent's Name (First, Middle, Last) Robert Edward C 4a. Facility Name (If not institution, give str	Coady		Se Se	Reg. No Date of Death Month Date ptember 3	y Year 5, 2007	3. Time of Death 1517 P M
Fu Dir	neral ector	er	Harford Memorial 5. Social Security Number 6. Sex 205-22-6019 Usual Residence of Decedent	Hospital 7. Age (In yrs. last birthday Yrs.	Months Days Hours	ace er 24 Hrs. 8 s Min.	Date of Birth (Month, Day, Year)	Pe	nplace (State or Foreign untry) NNSYLVANÍA
the Maryla	zea-i enor	Director	10a. State 10b. County Harsond 10e. Street and Number	10c. City, Town or L	e de Grace		10g Cit	izen of What Cou	10d. Inside City Limits 1 Yes 2 No
1215-0036 within 72 hours after death with the Maryland and	Interior is marked other then natural, or fems 23s or 25s-1 enow or other traumatic event, the Maxical Examinat must be notified at	by Funerai	313 Native Dance					U.S. Ameri Black, White Specify:	A. rican Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours aff and Mental Hygiene.	nt. Ihe Medica	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	Completed) (Give life.	dent's Usual Occupation a kind of work done during mo DO NOT use retired) Autonautical	Engine	P/L	Engine	
arylanc should be family Mental H	matic ever	To Be	Edward M. Coady 19a. Informant's Name/Relationship (Type)	Print) 19h Maili	18. Moti	Mildre	First, Middle, Maiden 2d Kwrtz Double Number City		- Code l
re, Ma s 1 end 2 s f Health an	other trau		Patricia L. Coady 20a. Method of Disposition	(Wife) 313 No	ative Dancer (Havre de		MD 21078
Baltimore, permit. Pages 1 er Depertment of Hea	any injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Harford I	matory or other place) Mem. Gardens 2. Name and Address of Face Llman Mitchel			Aberdee	n, MD
Physicien and Exam	ician dical niner	Icai Examiner	23 Part1. Enter the disease, or complications, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last d. d.	tions that caused the death. Do not en	ter the mode of dying, such a	ton St.	Havre d	le Grace,	Approximate Interval Between Onset and Death
Hecords, P.O. Box 68/ The law requires that the death certificate lie has been signed by the ettending phys	tached for use as the	Physician/Medi	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	very Day Year
COTGS, P. A requires that	eq	2	Part II. Other significant conditions contrib	2.4	inderlying cause given in Part ピロルビ	t I.	23e. Did tobacco u 1 ☐ Yes 2.		the cause of death?
	page 2	e Completed	25. Was case referred to medical				24a. Was an autopsy performed? 1 ☐ Yes 2 ► No	24b. Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available ompletion of cause of
UIVISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifies	the funeral director, p	ertification: To Be	examiner? 1	pital: 1 Impatient 2 ER/Outpatier 28a. Date ol Injury (Month, Day Year) 28b. Time o	nt 3 DDA Other: 4 N	Nursing Home 28d	theck only one 5 □ Residence 6 Describe how injury		(y)
DIVI	filled in by	O	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)			Location (Street and City or Town, State))	
To the Hos within 24 hr To the Fun	completely filled in by the	Medicai	one) Z Medical Examiner	ian: To the best of my knowledge, death . On the basis of examination and/or in and manner stated. **Learner** Mile **Learne	vestigation, in my opinion, de	eath occurred a	at the time, date and	place, and due to	to the cause(s)
	6		30. Name and address of person who comp ANDROW NOW	pleted cause of death (Item 23a) (Type, Attention of the Item 23b) (Type, Attention of the Item 25b) (Type,	Print) 36 FULS	CORP	AVE	BELAT	18 MD2/0/4
Re	Stat egistra	е	31. Date liled (Month, Day, Year) SEP 1 8 2007	38. Registrar's Signature	S.				

			1 - For Amend Item 3 pa	State of Marylan ar dr., g8/2, 10/18	d / Depa 3/0/dbb e/	artment of tificate o	Health an f Death	d Mental Hy	giene Reg. No.	007	29601
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	/Media		Fulton Trend Das					August			6:32 a. ^M
	Examir	ner	4a. Facility Name (If not institution, give s 4627 Coulbourn Mill				i, or Location of D Bburv	eath		nty of Death	
	Funeral		5. Social Security Number 6. Sex		last birthday)	II Under 1 Ye	ar If Under 24		th	9. Birth	place (State or Foreign
	Director		213-90-9874	M 2□F 40	Yrs.	Months Day	rs Hours M	Nov. 17	1966	Mary	yland
p	> 500		Usual Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	eation					10d. Inside City Limits
Aaryia	o H	ō	,			Cation					1 ☐ Yes 2 🖾 No
the	288-	Director	Maryland Wicomico 10e. Street and Number	Sal	lisbury	10f. Zip Code	9		10g. Citizen	ol What Cou	ntry?
death with the Maryland	38 ol	D	4627 Coulbourn Mill	Road		21	804		Ţ	JSA	
deat	E III	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of	l Hispanic Origin'	? (Specify Yes or No uerto Rican, etc.)	- 14. F	ace - Ameri lack, White,	
s after	or It	by Fu	1 Never Married 2 XMarried	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🕱 N			Spe	cifv:	
within 72 hours after	tural al Ex		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Decer	dent's Usual Oci	cupation		16b. Kind of		ack ndustov
G 1.		plet	(Specify only highest grade	College (1-4or 5+)	(Give		ne during most of	working			
A William	giene er the	Completed	Elementary/Secondary (0°12)	3	Sale	sman			Gas 8	oil,	Company
	and Mental Hygiene. s marked other than ". umatic event, tre Mes	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle,	, Maiden Sum	ame)	
should	J Men narke	은	Fulton Solomon Das		405 14-10			Handy	0'h	- 04-4- 7:	0-4-1
رت ض	th and 7 Is mu treum		19a. Informant's Name/Relationship (Ty) Sherry Dashiell/wi	-				r Rural Route Numbe oad – Sali			
5 1 and	T = =		20a. Method of Disposition	20b, P	lace of Dispo	sition (Name of		Date	20c. Location		
MILL Pages	nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	eniovanioni State		matory`or other ; Memory	į.	9/01/2007	Hebro	n. Mai	ryland
	Department of I Important: If Its eny injury or o		21. Signature of Funeral Service License					1213 Jersey			
<u>a</u> 8	8 2 2 8		Marien C	1. July				L CHAPEL			21801
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deal	h. Do not ent	er the mode of o			rrest,		Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)		hary	ngeal	(arciv	noma			4 years
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Šeše	cien au rurial-t	Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
The law requires that the death certificate be executed	physicien and the burial-transit	dical		J							
OX O	been signed by the attending property should be detached for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna	ıncy				23d	Date of deliv	rerv
death death	e atter	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregna Other (specify,				Month	Day Year
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o, r	pe eq	ρ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	given in Part I.		1		the cause of death?
w requires	s veer	eted						_ 10	Yes 2000	3 🗆 Pro	bably 4 Unknown
e law	r this certificete hes b	Completed						_ 24a. Was	an 24 psy prmed?_	b. Were auto prior to co death?	opsy findings available impletion of cause of
בי קב בי	ficete or, pag	e Co	25 Was asso referred to modical					1□ Yes	2 No	1 Yes	21 No
VILCII reiclan:	s certi	0 8	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatier	t 3 DOA	Other	Death (Check only only only only only only only only		Other (Speci	(64)
VISION OF VILA Attending Physician:	er this	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Vork?	28d. Describe			,,,
ondin o	or: Af	atlo	1 Natural 5 Pending 2 Accident investigation	(11011111)	,,		☐Yes 2☐No				
or Attending	olrect Direct in by 1	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, larm, str y)	eet, factory, office	CO CO	281. Location (. City or To		mber or Rur	al Route Number,
pital	erei E		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wlad a daatt	a occurred at the	time date and is	lace, and due to the	causals) and	manner as	stated
o the Hospital or	within 24 hours after death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	edical		ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in m	y opinion, death	occurred at the time,	date and place	e, and due	to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date sig	ned (Month	Day, Year)
	2		Physi	cian	_	H	57291			8/10	101
1	M.		30. Name and address of person who co	1 - 1	~	Print)	IN Siz	bury MD	2181	Ц	
	V		31. Date filed (Month, Day, Year)	820 Sweet Bay 32. Registrar's Signa	,	- Jute	101 /4(1)	inny MI	400		
	Sta Registr		AUG 3 0 2007	he de	1 "						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** .DAVI'S 5:50 PM JEAN dER 2007 /Medical 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE VA MediCAL CONTER NIA DALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F 1, Director 224-68-4334 Oct. 1947 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 TYPes 2 □ No Director MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2501 Violet Ave., U.S.A. Apt. 804N 21215 e filed within 72 hours after death all Hygiene.
other than "natural", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 0.6 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1966 1 Xes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 to 1969 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental F 7 is marked ot Gilbert Franklin Davis Dorothy Mae Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is a any injury or other trains once 13907 Edwall Dr., Upper Marlboro, MD Shirley Davis Gaines, Sister altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Quantico 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) National Cemetery 9/04/2007 Triangle, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8914 Quarry Road O Johns Ames Funeral Home, Inc. Manassas, VA 20110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) WHER EASTRO INTESTRATE Physician /Medical Due to (or as a consequence of) Examiner AYPOXIA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): INFARETION MYJCAMDIAL attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of). P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No detached the 9☐Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 🔲 Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 11 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**□** No 1 Lanpatient 1 ☐ Yes 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After Division Hospital or Attending 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after the Funeral 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Megical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature ar 29d. Date signed (Month, Day, Year) 2

State Registrar 30. Name and

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AUG

31. Date filed (Mosth, Day,

of person w

Year)

30

DHMH 17 Rev 1/2001

10 North Greene Street BA 4: more MD 2120/

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

JAMES

GUZZO

			For State Registrar	tate of Mary		artment of H rtificate of I		Mental Hyg	jiene _{eg. No.} 20	07	29603
	Physici		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic			Lillian B	. Dodd			Septemb	per 5 2	.007	0005 A M
)	Examin	er	4a. Facility Name (If not institution, give stree Union Hospital	t and number)		4b. City, Town, or E1ktor	Location of Death	l	4c. County	y of Death	
96 	Funaval	*	5. Social Security Number 6. Sex	7. Age (II	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthn	lace (State or Foreign
	Funeral Director		220-24-2893 ^{1□ M}		Yrs.	Months Days	Hours Min.	DEC 4,	, _{Year)} 1926	West	Virginia
- 8	P .		Usual Residence of Decedent		02 T						
	arylar show d at	<u>-</u>	10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits 1 1 Yes 2 No
	the M 28a-f lotifie	Director	Maryland Cecil 10e. Street and Number		Elkton	10f. Zip Code		1	0g. Citizen of	What Cour	71
	with 3a or t be r	Ö				21921				ed St	
	death ms 2%	Funeral	100 Laurel Drive 11. Marital Status 12. \(\)	Was Decedent Eve	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Ra	ce - Americ	an Indian,
9	after or ite	Ē	1 Never Married 2 Married 1	Armed Forces? I □ Yes 2 X No If Yes, Give		nr Yes, speciny Cuba 1 □ Yes 21 <mark>7</mark> No	Specify:	o Rican, etc.)		ack, White,	
21215-0036	ural",	d by	3 X Widowed 4 □ Divorced	Year or Dates:		21				Mhi	
2	ר 72 ה "natu edica	Completed	15. Decedent's Education (Specify only highest grade con		16a, Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind of E	Business/In	dustry
7	withir ene. than he M	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	,		In He	r Own	Home
g	be filed within 72 hours after death with the Maryland ttal Hygiene. Independing the matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,			
<u> a</u>	should be filed nd Mental Hygi marked other matic event, t	To B	Oscar Dean Mahala				Flora F	rice			
Maryland	S S S		19a. Informant's Name/Relationship (Type. I		1	ng Address (Street			-		
	and lealth m 27 her tr		Harry E. Dodd, Jr./			esa Aveni			Marylan 20c. Location		
ğ	Pages 1 and 2 nent of Health int: If item 27 i		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Remo	oval from State	20b. Place of Dispo cemetery, crei		16	ember	West (Cheste	er.
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		R.A. Ferris	Name and Addre	ss of Facility		Pennsy		
æ	Depart Impo		2	H. a.	H	icks Home 33 W. Sto	for Fun	erals, P	A. kton N	Marv1a	and 21921
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F.	/Medical Examiner		resulting in death)	Due to for as a co	onsequence on:						
	Examine	_	Sequentially list conditions, if any, leading to immediate	A core	onsequence of): - Eug	etury f	3 ilure				C72 Horrs
9	ted nsit	nine	Cause. Enter Underlying Cause (Disease or injury	OPI		ah. cen a	faus t				Ch/ource
<u>z</u> 5.	execu n and ial-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a co	onsequence of):	1775044	10-5 17	p C			
58760,2	icate be executed physician and s the burial-transit	edical	d								
	rtifica ng ph		IF FEMALE:								
ROX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as for	Physician/M	23b. Was decedent pregnant in the past 12 months?	If yes, outcome pf p 1 Live birth 2	Fetal death 3	Ectopic pregnancy	1			ate of deliv	ery Day Year
	he de the a	ysic	1 Type 2 No	4□Pregnant at tim 9□Unknown	ne of death 5L	Other (specify) _					,
J. O.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contrib	uting to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to t	he cause of death?
Vital Records,	quires n sign ild be	d by	Chronic renal	insuffic	icincy			1 □ Y	es 2□ No	3 Prol	pably 4 Unknown
<u>ဂ</u>	aw rec s beel	Completed	Rheumatic Hea	ert Dis	6616			24a. Was a		. Were auto	ppsy findings available
Ä	The Ist	mo						autop perfor 1∏ Yes	med2 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of 2□ No
Ta Ta	hysician: The law his certificate has t I director, page 2 s	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only or			
<u>~</u>	hysic his ce	To	1 ☐ Yes 2 No Hosp	Inpatient	2 ER/Outpatier		4 Nursing F	lome 5 Resid			fy)
ב	ing P		1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time o	Wor		28d. Describe h	ow injury occu	urred	
1210	death ctor: , the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury	- At home, farm, str		Yes 2 No	28f. Location (S	treet and Num	ber or Run	al Route Number,
Division or	after after Direct din by	Certification:	4 ☐ Homicide determined 2	building, etc. (Specify)			City or Tow	n, State)	.50, 0, 7,0,,	ar riodio Hamboi,
	ospita hours uneral		29a. Certifier 1 Certifying Physicia								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical		and manner stated	d,						
	Voith To To To To To To To To To To To To To	Σ	29b. Signature and title of certifier	<i>a</i>		29c. Licens	e number	1	29d. Date sign		8 2007
			Inful afing My						-		
	5		30. Name and address of person who completed A P. 110	leted cause of death	n (Item 23a) (Type,	rant)	06 Bow	Street	ELICH	-0 "	,40
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	h (Item 23a) (Type,	relie				/	
			ACD 4 2 2007	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A STATE OF THE STA						

State of Maryland / Department of Health and Mental Hygiene

2007 29604

		Registrar Certificate of Death Reg. No.												
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) 2.	2. Date of Death Month Day September 5, 2007 3. Time of Death 1205 hrs											
*		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 12 Lewisville Road Elkton		4c. County of Death										
Funeral Director		Months Days Hours Min	B. Date of Birth	MM/DD/YYYY) 9. Birt Foreig	nplace (State or Delaware									
Director	-		Feb. 15	. 1918 Co.	intry)									
w any	Ī	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits										
Maryland 28a-f show 1 at once.	휭	Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code	1 Yes 2 X No											
ith the Maryland 23a or 28a-f sho notified at once	Director	12 Lewisville Road 21921		United St										
ith with tems 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric	ify Yes or No- can, etc.)	14. Race - Americ										
after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once	by Fu	1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No 1 Yes 2 X No specify:	Specify: White											
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Montal Hygiene. Itant: Witem 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)												
MD 21215-0036 d 2 should be filed within 72 hours th and Mortal Hygiene. n 27 is marked other than "natur numatic event, the Medical Exam	Completed	12 Homemaker	131	In Her Ow	Own Home									
15-0 filed w al Hygie ed othe		17. Father's Name (First, Middle, Last) Stanislaw Ochenkowski Feliksa Pi	me (First, Middle, Maiden Surname)											
2121 2121 21d be fil Montal I marked ic event,	o Be		Plersa Rural Route Number, City of Town, State, Zip Code)											
MD dd 2 shoulth and m 27 is aumatic		James Draper/Son 962 Rahway Drive, Newar												
ore, MD 2 ges I and 2 shou of Health and N If item 27 is n ther traumatic		1 X Burial 2 Cremation 3 Removal from State D frematory or other place) Septe	ember	20c. Location - City or										
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr		4 Donation 5 Other Specify: Memorial Cemetery 11, 2		Bear, Dela										
		21. Sunature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funer 103 W. Stockton Stre	cals, P eet, Ell	.A. kton. Mary	land 21921									
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death									
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Injuries Due to (or as a consequence of):												
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	77											
. 2.	Examiner	Colsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
760, (c) icate be executed by physician and the burial - transit		d.												
O, e be ex rsician burial		UNPENDED												
∞ # # # # # # # # # # # # # # # # # # #	Ě	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery ncy Month Day Year											
Box 6 e death cer the attendii	Physician/Medical	1 Yes 2 ✓ No 9 Unknown g Unknown												
P.O. E	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?											
S, P	ed by	Atherosclerotic Cardiovascular Disease	1 Yes 2 No 3 Probably 4 Unkno											
cord law req has bee	Completed		24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of									
Rec The ficate page	S		1 ✓ Yes 2		s 2 No									
ician:	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outcatient 3 DOA Other's Nursing F		anidaman S.a.d. Other										
of V Phys eral di	의	27 Manner of Death 128a Date of Injury 28b Time of Injury 28c Injury at Work2 28	ng Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred											
ion C tending eath. for: Af	틽	1 Natural 5 Pending ProUND: Pound Pround Pro												
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28	28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Lewisville Road, Elkton, MD											
Hospit 24 hour Funera	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du	e to the cause	s) and manner as state										
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.												
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 6, 2007											
20		30. Name and address of person who completed cause of death (Item 23a)												
19	10	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 3 2007	21201		***									
Sta Regist	ие Гаг	31. Date filed (Month, Day, Year) SEP 1 3 2007 32. Registrar's Signature												

State

Registrar

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HOSPITAL

Registrar's Signature

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JABER

1 3 2007

31. Date filed (Month, Day, Year)

SEP

			1- State of Maryland / Dep Registrar Ce	artment of Health and rtificate of Death		giene 2007	29606								
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death								
	Physic /Medi		Karl V. Esmark		8 Month	30 2007	8:40 A M								
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death									
			Atlantic General Hospital	Berlin		Worcester									
	Funeral Director		5. Social Security Number 6. Sex 120 M 2 F 85 Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Mir		, Year) C	9. Birthplace (State or Foreign Country) NJ								
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town on Line	ocation			10d. Inside City Limits								
	f sho	ō													
	28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou												
	3 with		9406 Pitts Rd.	21811		USA	,								
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-		American Indian,								
y.	atter death with the Marylar or iteme 23e or 28e-f ehow tritier must be coliffed at	Ē	Armed Forces? 1 Never Married 2X Married 1X Yes, 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Pue	no Hican, etc.)		ck, White, etc.								
7	72 hours "natural",	d by	3 Widowed 4 Divorced Year or Dates: WWII	1 ☐ Yes 2X No Specify:	Specify: W]	nite									
20	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or iteme 23s or 28s-f ehow out, the Madical Examinar must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	16b. Kind of Business	/Industry									
2 35	withir Bne.	Ę,	Elementary/Secondary (0-12) College (1-4or 5+)	ool Principal		Educatio	. n								
1 -6	filed Hygi nt,	e C	17. Father's Name (First, Middle, Last)		me (First, Middle, i)II								
04/04 08/30 Maryland	should be filed within id Mental Hygiene. marked other than matic event, the M	To B	Henry M. Esmark		1 Meyers	,	<u>-</u> -								
7 62	2 should and Mer is mark aurmatic	-		ng Address (Street and Number or F		r, City or Town, State,	Zip Code)								
\ \ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	1 and 2 s Health an tem 27 is		Emma Esmark / Wife 9406	Pitts Rd., Berl	in, MD 21	1811									
0 0	0		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - City of	Town, State								
825	Pages nent of I ant: if ite		PED DUNAL 2 DOMINATION 3 DINGHIOVALITORI STATE		/2007	Berlin, M)								
OUD- Ballimore	permit. Page Department of Important: If eny injury or once.		21. Signature of Funda Service Licensee 22. Name and Address of Facility Burbage Funeral Home												
	80 5 5 8	11/		.08 William St.,											
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between								
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Myocardial 7	nfaction			Onset and Death								
	/Medical Examiner		Due to or as a consequence of:												
	Examiner	_	Sequentially list conditions, b. Congestive Heart Failure												
	ted Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Congestive Hewt Failure Due to (or a a consequence of): Acute Renal Failure												
	be executed sicien and burial-transit	Examiner	cause (Disease or injury that initiated events resulting in death) Last C. Acute Renal Failure Due to (or as a consequence of):												
8760	cate be executed physicien and the burial-transit	dical													
68	ificate g phys	edic	0.												
ă	eath certific attending p	№	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3		23d. Date of de	livery								
Z Cum	death	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year								
300	es that the de igned by the be detached	hys	9 Unknown	1											
800	es th igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	†	bacco use contribute t	1								
A 1 P	v requir	ted	Drabetes mellitus		1 🗆 Ye	es 2 □ No 3 □ P	No 3 Probably 4 Unknown								
> 000	e taw has b	Completed by Physician/Me	Anemia		24a. Was a autops	n 24b. Were a prior to	utopsy findings available completion of cause of								
7 7	n: The ticate har, page	Ö	Seizure disorder, Deme	ntia	perform 1 Yes 2	Ted? death? 2 XNo 1 ☐ Yes	2.XNo								
5 7 Z	sicier certif recto	Be	25. Was case referred to medical examiner? Hospital:	Othor	ath Check only on										
7	ding Physicien: Atter this certific tuneral director,	٠ <u>.</u>	1 tes 215010 1 te npatient 2 EH/Outpatier	T 30 box 40 Indising	T	ence 6 Other (Spe	cify)								
, c	ding th. : Atte	ti	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,									
Division	Attending death death ector:	Hice	3 Suicide 6 Could not be	eet, factory, office	28f. Location (St	reet and Number or R	ural Route Number.								
id	s afte	Certification;	4 Homicide determined building, etc. (Specify)												
	To the Hospital or Attending Physicien: The law requires that the death certification 24 hours after death. To the Function 24 hours after death site certificate has been signed by the attending to completely titled in by the tuneral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner stated. (Check only one)												
_	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mon	e signed (Month, Day, Year)								
			Jason Samel DO	40064425	3	08/30/	8/30/2007								
	0.	j	30. Namy and address of person who impleted cause of death (Item 23a) (Type,	Print)		001001	010012007								
	BAGHI		Jason Szymala Do 9733 Healthu	my Drive Berl	in, MD2	1811									
	Sta Registr		29b. Signature and title of certifier Assort Symala DO 30. Name and address of person in impleted cause of death (Item 23a) (Type, Tason Szymala DO 31. Date filed (Mortin, Day, Year) 32. Registrar's Signature 33. Registrar's Signature 34. AUG 3 1 2007	book	•										
	1.091511	-	AUG 3 I LOUI THE PARTY OF PARTY												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** William H. Fearer 2007 6:00 A M Aug 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1080 Crestview Drive Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1X M 2□F 219-34-5890 69 Maryland Director Mar 24, 1938 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Annapolis 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1080 Crestview Drive 21409 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: White 9 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pharmaceutical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Fearer Willa Delaney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1080 Crestview Drive, Annapolis, MD 21409 Mariam E. Fearer/ Wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 28, 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June al Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 -23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STASE CHRONIC OBSTRUCTIVE PULMONARY
as a consequence of):

DISPASE **Physician** END 710 Y FARJ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Tes 2 JEN 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation

P.O. Box 68760, Division or Vital Records, funeral director, page 2 or Attending Hospital

Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

12

State Registrar

29b. Signature and title of certifier

6 Could not be determined

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier (Check only one)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🗔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person in completed cause of death (fiem 23a) (Type, Print)

M) - PRINCE FREDERICK, M) 20678

AUGUST 28 2007

31. Date filed (Month, Pay, Care

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

07-06614

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 29608

Matthew Dennis I		es St For State	ate of I	Marylar		artment of rtificate of		and	Menta	al Hyg		on No	20	U /	2960
* Physicia		Registrar 1. Decedent's Name (First, Midd	e,Last)			tinodio or	Dodin			2	. Date of Dea	th	Year	3. Time of	
Medical Examin		Matthew	Denn	is 	Forbe				,		Month August 26	6, 200°	7	07291	nrs
•		4a. Facility Name (if not institute 520 Pinehurst Avenue		eet and num	ber)	14	b. City, To Salisbu		ocation of	Death			. County of Dea Vicomico	ın	
Funeral		Social Security Number	6. Sex	7	. Age (In yrs. I	ast birthday)	If Under	•	If Under	24Hrs.	8. Date of Bi	rth(MM/	DD/YYYY) g. B	irthplace (Sta	te or
Director		228-45-8212	1 X M		20	Yrs.	Months	Days	Hours	Min.	04/03	/198	7 Fore	^{ign} ^{ount} Viro	inia
	-	Usual Residence of Decedent	I A W												
v any.		10a. State 10b. County			10c. City	, Town or Locati	on								e City Limits
and f show	ō		.comico			alisbury					1100		g. Citizen of What Country		
Mary r 28a- ed at	Director	10e. Street and Number 911 Camden Ave.					10f. Zip Code 21801					rog. Citi	USA	cartay:	!
ith the							Was Decedent of Hispanic Origin? (Specify Yes or No.						14. Race - Ame	erican Indian,	Black,
eath w	Funeral	1 X Never Married 2 Married Armed Forces?					f Yes, specify Cuban, Mexican, Puerto				Rican, etc.)		White, etc.		
sfter d	by Fu	3 Widowed 4 Di		1 Yes 2 X No specify:						Specify. White					
natura Xami		15. Decedent's Education (Spe				16a. Deceden during m	t's Usual O ost of work					16b.	Kind of Busines	s/industry	
36 in 72 l	plet	Elementary/Secondary (0-12)		College (1-	4 or 5+)								educati	on	
-000 I within giene lher the	Completed	12 17. Father's Name (First, Middle		2		Stu	dent	1	8.Mother	s Name (First, Middle,	, Maider			
215 oe filec ked o	Be C	Dennis Forb									offman				
21; nould t ad Mer is mar fic eve	T _o	19a. Informant's Name/Relation				1							City or Town, Sta		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show injury or other traumatic event, the Midical Examiner must be notified at once.		Dennis Forbe	s/Iat	ner	20h	Place of Dispos				Sa.	Date		D 21801 Location - City		ie
Ore,		1 Burial 2 X Crematic	n 3 🗌	Removal fro	m State	crematory or ot	her place)								
tim t. Pag rtment rtant:		4 Donation 5 Other Specify: Salisbury Crematory 8/28/07 Salisbury MD 21 Status of Euneral Service Licensee 22 Home Professional Asso													
Bal permi Depa Impo injur		mily	01				01 Sn	ay .	runer Hill	Rd.	, Sali:	roie sbur	ssionai y, MD 2	1804	ciation
Physician		3a. art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and													
/Medical	4	Immediate Cause (Final diseas	e a.Ha	noino							<i>a</i>				Death
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iO, e be executed ysician and burial - transit	edical														
Box 68760, e death certificate be the attending physicied for use as the buring the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in			outcome of pre			3	Ectopia	c pregna	nev	2	3d. Date of deliversely Month	very Day	Year
C 68	sician/M	past 12 months?		1 Live b 4 Pregn	irth ant at time of c	tooth -	etal death ther (Spec	ify)	Ectopic	pregna	iicy		Month	5-,	
BOy e death the att	Physi			9 Unkno							Loo. Di-		o use contribute	to the cause	of death?
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	by P	Part II. Other significant cond	itions co	ntributing to	death but not	resulting in the	underlying	cause g	iven in Pa	art I.			No 3 F		
Division of Vital Records, P.O. ral or attending Physician: The law requires that the rs after death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed k										24a. Wa		24b. Were	autopsy find	ings available
corc	ıple						<u> </u>				per	topsy rformed	? death		
Re(The ficate; page	Be Completed	05.111						6 Place	of Death	(Check (s 2	No 1 🗸	Yes	2 No
'Ital sician is certi lirecto		25. Was case referred to medic examiner?		pital:					Other Nursing Home 5 Residence				dence 6 🗸 O	ther: Scene	
n of Vital Rec ling Physician: The I After this certificate I funeral director, page	. To	1 ✓ Yes 2 No 27. Manner of Death	Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject hanged self												
ion tendin eath. tor: A	atior	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Aug 26, 2007 Aug 26, 2007 Aug 26, 2007 Aug 26, 2007 Aug 27. Manner of Death 1 Yes 2 No 28d. Describe how injury occurred Subject hanged self													
ivis or At after d Direct	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide 6 Could not be determined (Specify) School 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) School 28f. Location (Street and Number or Rural Route Number, City or Town, State) 520 Pinehurst Avenue, Salisbury, Md.													
D sspital hours meral y filled		4 Homicide	ermined		School			timo d	ato and al						
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s))		
with To I	Med	29b. Signature and title of cert	ar	nd manner s	tated.				e number				Date signed		
		1/10	11	7/-	of In.	1		O.C.	C.M.E.			August 27, 2007			
W M		30. Name and address of pers	on who con							144	1 / P - / -	04			
		Theodore M. King, J			e .	Examiner			reet, Ba	altımor	e, MD 212	201			
S	tate	31. Date filed (Month Day, Yea	0 200	7 32. 6	egistrar's Sign	ature	ands)								

07-06607 Ве

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enjamin Fennell			/ Department of Health and Mental Hy	^{/giene} 2007 2960
		- For State Registrar	Certificate of Death	^{/glene} 2007 2960
Physicia		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 0050 bro
ledical Examin		Benjamin HIIZA	rennell	August 26, 2007 0050 hrs
		 Facility Name (if not institution, give street and number) Peninsula Regional Medical Center 	4b. City, Town, or Location of Death Salisbury	4c. County of Death Wicomico
Eurogal	4		le (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		589-20-2947 1×1 20F	27 Yrs. Months Days Hours Min.	avg, 20, 1980 Foreign Country) Illonois
		Usual Residence of Decedent	0 1 113.	1909,90,11001 21100018
any		10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
nd show	۱,	Md Howard Co.	Colombia	1 Yes 2 No
Maryk 28a-f d at o	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th the Maryland 13a or 28a-f show		KILAIJARO RO		United States
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces		ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
er dea		1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	No 1 Yes 2 No specify:	Specify: Rlack
ursaft	<u>8</u>	15. Decedent's Education (Specify only highest grade cor	mpleted) 16a. Decedent's Usual Occupation (Give kind of w	
72 hours n "natur al Exam	etec	Elementary/Secondary (0-12) College (1-4 or	5+) during most of working life. DO NOT use retir	$\mathcal{O}_{\alpha}(i)$
5-0036 led within 7 Hygiene. I other than	Completed	8	Night Manag	er Restaurani
Filed v Hygi d other		17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname) A HARMON
Z de de s	o Be	WAKDELL FE 19a. Informant's Name/Relationship (Type, Print)	NNELL Emmi	Rural Route Number, City or Town, State, Zip Code)
MD 2	-	Wardell Fennell (fat		Salishuri, md 21804
		20a. Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Pages 1		1 Burial 2 Cremation 3 Removal from St 4 Donation 5 Other Specify:	St. James Church Cem 9-	1-07 Itead-of-the-Creek, Nd
Baltimore, perrit, Pages I ar Depriment of Hee Impriant: If ite		27. Signature of Euneral Service Licensee	22. Name and Address of Facility BENNIE Smith	917 W. Isabella Street
		My red	FUNERAL Home	Salisbury, maryland 21861
Physician /Medical		failure. List only one cause on each line.	the death. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, o peart Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or continon resulting in death) a. Stab wound of Due to (or as a constant of the continuous constant of the continuous con	chest and cutting wound of right forearm	Deaui
		Sequentially list conditions, b.	equence or,.	
	ner	if any, leading to immediate cause. Enter Underlying Cause	sequence of):	son the son the
	caminer	(Disease or injury that initiated events resulting in death) Last	sequence of):	
e executed cian and rial - transit	Ë	d		
be execut sician and urial - tra	dical	UNPENDED AMENDED		
Box 68760, e death certificate be the attending physic ed for use as the bur	sician/Me	23b. Was decedent pregnant in the	ome of pregnancy Petal death 3 Ectopic pregna	23d. Date of delivery ancy Month Day Year
x 68 h cert tendin	icia	past 12 months?	at time of death 5 Other (Specify)	
BO)	Phys	1 Yes 2 No 9 Unknown g Unknown		23e. Did tobacco use contribute to the cause of death?
ords, P.O. I v requires that the sbeen signed by t	J. P.	Part II. Other significant conditions contributing to dea	th but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown
ords,	Completed			24a. Was an 24b. Were autopsy findings available
COFC law re has be	nple			autopsy prior to completion of cause of death?
tal Rec cian: The l certificate	S		26 Place of Death (Check	1 Yes 2 No 1 Yes 2 No
Vital Recolysician: The law	Be	25. Was case referred to medical examiner?	Othor	ng Home 5 Residence 6 Other:
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should be a been to be a been a been a been a been a been a been a been a been a been a been a been a been a been a been a been a been a been a be a be	<u>۱</u>	1 V Yes 2 No 28a. Date of In	jury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
OD C	ţion	1 Natural 5 Pending FOUND: Aug 26, 200	1 105 2 4 110	Subject stabbed and cut
/iSion Attender de Directe	fica		Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	4 Homicide determined (Specify) O	utside Convenience Store	or Town, State) 910 West Road, Salisbury, Md.
e Hos 124 ho e Fun letely		(5.115)	my knowledge, death occurred at the time, date and place, and amination and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated.
To th within To th compl	Medical	and manner stated		29d. Date signed (Month, Day, Year)
	2	29b. Signature and title of certifier	O.C.M.E.	August 26, 2007
Only		20 Name and addition of parent who completed source of		
40		30. Name and address of person who completed cause of Mary G. Ripple MD. Deputy Chief Med	lical Examiner 111 Penn Street, Baltimore, N	MD 21201
St	ate	31. Date filed (Month, Day, Year)	rar's Signature	
Regist		AUG 2 3 200. Allegar	· (h //www.p)	

Registrar

DHMH 17 Rev 1/2001

Diane Georgia Franklin

2007 29611

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location RI NEWPORT TIVERTON 10g. Citizen of What Co 10g. Citizen of What Co 11g. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 1 Neve	irthplace (State or ign country) TOWA 10d. Inside City Limits 1 X Yes 2 No
DIANE GEORGIA FRANKLIN 4a. Facility Name (if not institution, give street and number) Woods at Beech Drive and Cedar Lane 4b. City, Town, or Location of Death Wonds at Beech Drive and Cedar Lane Bethesda Montgomery 5. Social Security Number 483-84-9710 1 M 2 X F 46 Yrs. 46 Yrs. August 31, 2007 4c. County of Death Montgomery	irthplace (State or ign country) IOWA 10d. Inside City Limits 1 X Yes 2 No
Woods at Beech Drive and Cedar Lane Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 483-84-9710 1 M 2 X F 46 Yrs. Usual Residence of Decedent 10a. State 10b. County Montgomery 7. Age (In yrs. last birthday) Months Days Hours Min. JAN. 25, 1961 County	irthplace (State or ign country) TOWA 10d. Inside City Limits 1 X Yes 2 No
Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 483-84-9710 1 M 2 X F 46 Yrs. 6. Sex 7. Age (In yrs. last birthday) Months Months Months Months Months Months Months JAN. 25, 1961 Guerral 10a. State 10b. County 10c. City, Town or Location	ign (country) IOWA 10d. Inside City Limits 1 X Yes 2 No
Director 483-84-9710 1 M 2 X F 46 Yrs. Months Days Hours Min. JAN. 25,1961 Fore C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	ign (country) IOWA 10d. Inside City Limits 1 X Yes 2 No
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No
* .	1 X Yes 2 No
TIVERTON RI NEWPORT TIVERTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Co 171 CRANDALL RD. 11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 3 New Married 1 Never Married 3 New Married 1 Never Married 3 New Married 1 Never Married 3 New Married 1 Never Married 3 New Married 1 Never Married 3 New Married 1 Never Married 4 New Married 1 Never Married 5 New Married 1 Never Married 5 New Married 1 Never Married 5 New Married 1 Never Married 5 New Married 1 Never Married 5 New Married 1 Never Married 5 New Married 1 Never Married 5 New Married 1 Never Married 6 New Married 1 Never Married 7 New New Married 1 Never Married 8 New Married 1 Never Married 8 New Married 1 Never Married 9 New Married 1 Never Married 1 New Married 1 Never Married 1 New Married 1 Never Married 1 New Married 1 Never Married 1 New Married 1 Never Married 1 New Married 1 Never Married 2 New Married 1 Never Married 1 New Married 1 Never Married 1 New Married 1 Never Married 2 New Married 1 Never Married 1 New Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Married 1 New Married 1 Never Married 2 New Ma	
10g. Citizen of What Co	untry?
171 CRANDALL RD. 12. Was Decedent Ever in U.S. Armed Forces? X yes 2 No	
1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No No No No No No No No No No No No No	
현 등림 군	ericali iridiali, biack,
필 : 형 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Vision 1 Specify: Vision	HITE
3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: We ware or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	/Industry ·
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business during most of working life. DO NOT use retired) 17b. Father's Name (First, Middle, Last) 17c. Father's Name (First, Middle, Last) 18d. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18d. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17c. Father's Name (First, Middle, Last)	,
State at 5 1	SE
	TN
TO BE SECONDE FRANKLIN MARY LYNETTE KLE STORM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta	
DOUGLAS A. CARLO/HUSBAND 171 CRANDALL RD., TIVERTON, RI. 02878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of the control of	
20a. Method of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place)	or Town, State UNK •
LEA BEA ATLANTIC OCEAN	
20c. Location - City of Crematory or other place) 20c. L	, P.A.
MO091 5801 CLEVELAND AVE., RIVERDALE, MD.	20737 Approximate Interval
Medical failure. List only one cause on each line.	Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions,	
if any, leading to immediate Due to (or as a consequence of):	- 1
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
OBDINARY CONTROL OF CO	
	ery Day Year
past 12 months? The past 12 months Pregnant at time of death Descrity Descrit	- 1
Part II. Other significant conditions The past 12 months? The past 12	to the cause of death?
O to provide the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 W No 3 Provided the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute I 1 Yes 2 W No 3 Provided the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
He law requires that The law requires that	autopsy findings available
autopsy prior to	
Description of Death (Check only one) 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	Yes 2 No
THE STATE OF THE S	er: Scene
Nursing Home 5 Residence 6 ✔ Oth Oth Oth Oth Oth Oth Oth Oth Oth Oth	
27. Manner of Death 1 Natural 28a. Date of Injury FOUND: 1 Natural 28b. Time of Injury FOUND: 1 Yes 2 No 28d. Describe how injury occurred Subject hanged self 1 Yes 2 No 28d. Describe how injury occurred Subject hanged self	
24a. Was an autopsy performed? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Was an autopsy performed? 28. Unspecial of the plant of the plant of the plant of the performed? 28. Unspecial of the plant of the plant of the performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Was an autopsy performed? 28. Unspecial of the property of the performed? 28. Unspecial of the performed o	•
3 Suicide 6 Could not be determined (Specify) Woods 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Woods 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Woods 28e. Detail of Street and Number of Four Town, State) Woods at Beech Drive and Ceda 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Detail of Street and Number of Four Town, State) Woods at Beech Drive and Ceda 28e. Detail of Specify) Woods	
T Received at the time, date and place, and due to the cause(s) and mainter as so	
29b. Signature and title of certifier 29d. Date signed (No. 2) 29d. Date signed (No. 2) 29d. Date signed (No. 2)	
O.C.M.E. September 1, 2	2007
30. Name and address of person who completed cause of death (Item 23a)	
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	····
State 31. Date filed (Month, Day, Year) Registrar 32. Registrar's Signature	

within 2 To the State

24 hours a Funeral I

filled in by

Medical

31. Date filed (Month, Day, Year) AUG 2 8 2007

29b. Signature and title of certifier

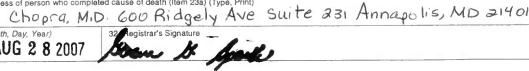
4 Homicide

Aditya

29a. Certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 5057028

29d. Date signed (Month, Day, Year)

				artment of Health and I rtificate of Death	Mental Hygie Reg.	2007 29613
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) Charlie Morton Hurd, Sr.		August :	30, 2007 3:55 A M
	Exami	ner	4a. Fecility Name (If not institution, give street and number) Genesis Eldercare Center 5. Social Security Number 6. Sex 18 M 2 F 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death La Plata) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Charles 9. Birthplace (State or Foreign
	Director	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation a Plata	Aug. 16,	1938 Vermont 10d. Inside City Limits 1 □ Yes 2 💆 No
	ath with the 23a or 28e pust by notil	rai Director	10e. Street and Number 8434 Cooksey Road	10f. Zip Code 20646	5	Citizen of What Country?
9036	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23s or 28e-1 show he Medical Exam er must be revilled at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Xeyes 2 No If Yes, Give Year or Dates: 1956-58	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036		Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) Carpenter	king	Union
arylan	2 should be filed and Mental Hygi is marked other eumatic event, i	To Be	Franklin Harry Hurd		ne (First, Middle, Maio Zzie Irene Iral Route Number, Cii	Davis
Baltimore, Ma	of Health a litem 27 is		Marilynn J. Hurd – Wife 8434	Cooksey Road, La	Plata, MD	
Balti	permit. Page Department of Important: If any njury or phose.		21. Signature of Funeral Service Licensee M00053	2. Name and Address of Facility Untt Funeral Home	3035 01c Waldorf,	d Washington Rd. , MD 20601
68760,	ificate be executed The physician and physician and physician and physician and physician are the burial-transit	edicai Examiner	23a. Part1 Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac TOMACH LIVER. INVER.		Approximate Interval Between Onset and Seath & Manual Manu
О. Вох	death certif e attending id for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Q .	w requires thet the been signed by the should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	2 No 3 Probably 4 Unknown
al Reco	The law ete has b page 2 s	e Completed			24a. Was an autopsy performed	
Division of Vital Records,	ding Phys h. After this funeral di	Certification; To Be	25. Was case referred to medicat examiner? 1 Yes 2 No	ont 3 DOA Other: 4 Manursing Ho f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	and Number or Rural Route Number.
۵	To the Hospital or Atten within 24 hours after deat To the Funerel Director; completely filled in by the	Medicai Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatted the control of the pasts of examination and/or in and manner stated. 29b. Signafure and title of certifier	h occurred at the time, date and place, vestigation, in my opinion, death occur	, and due to the cause rred at the time, date a	a(s) and manner as stated
(/	30. Mane and address of person who completed cause of death (Item 23a) (Type,) 02067	9	8/30/2007
	B 2.		31. Date filed (Month, Day, Year) AUG 3 1 2007 32. Fegistrar's Signature	N WALDO	RF. M	W. 20605

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** aRRI 2120 M 08 2007 les /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours **X**XM 2□ F Vrs Director Dec. 291-36-8857 66 1940 Ohio Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2XXNo Director Florida Collier Naples 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 8677 Gleneagle Way 34120 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. MXYes 2 No 1964− If Yes, Give Year or Dates: 1964 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3√Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Marketing Sales Executive Appliance Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If Item 27 is marked or any injury or other traumatic ev Charles Edward Harris, Sr. Frances Catherine Staubach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Fitzmaurice / Daughter 243 Three Creeks Drive Centreville, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2/13 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 8/27/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATOR **Physician** /Medical Due to (or as a consequence of): Examiner ADVANCED Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CHROWIC burial-tran Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | signed by the a d be detached f 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 ALLURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy certificate 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) pupatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 20 No 2 After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. al or Attendi s after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical sampletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies

State Registrar

31. Date filed (Month, Day, Year) AUG 2 8 2007

HUWDER

lame and address

32. Resistrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL OR.

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ANNAPOCIS

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JOSTA

Herber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Angust Day th Year **Physician** 9:38 AM Randall milton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbi Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. 28, 1951 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Washington,DC 216-58-5123 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Howard Jessup 1 □Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8746 Cheshire Court 20794 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 (1) No If Yes, Give 1969-1972 Year or Dates 1969-1972 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hawkins Woodrow Laura Rossman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8746 Cheshire Court Jessup, Maryland 20794 Heidi JoAnn Hawkins -wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 9/5/2007 Cheltenham, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine alor Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and Dovole attending physician and for use as the burial-tran as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1□ Yes 24 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D TUC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2007

ran

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)



Clarkenelle MD

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** August 28, 2007 6:15 P M Harlas Mesuir *Harris* /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 318 Lanafield Circle Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Hours Days 1**∑** M 2□ F Yrs. 77 May 15, 1930 265-38-3368 Indiana Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 XYes 2 No Directo Maryland Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 318 Lanafield Circle 21713 U.S.A.Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (n and Mental H Samuel Budd Harris Florence Evelyn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau (Wife) 318 Lanafield Circle Boonsboro, Maryland 21713 Lue Hilda Harris 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 M01414 **wis** 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Malnutrition Physician months /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Bowel Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Emply attending physician and for use as the burial-tran Due to (or as a consequence of Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached t Division or Vital Records, P.O. 9 Unknown ate has been signed l page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 res 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe certificate 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 ☑Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital l 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14996 30. Name and address of person who completed cabse of death (tigm 23a) (Type, Print) Cappans Rd Beensburo MD 21713 31. Date filed (Month, Day, 32 Registrar's Signature Year! State 13 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 107 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0550YAM Lawrence Wilbur Harbaugh Angust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days Months 1**X** M 2□ F 92 213-12-7220 Director Feb. 16, 1915 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If New 27 is marked other than "natural" --- any injury or other traumatic exercises. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 ☐ XIo Md. Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20009 Rosebank Way 21742 U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ X/es 2 □ No
If Yes, Give
Year or Dates: 40-43 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Never Married ★ Married 1 ☐ Yes 2**X**☐ No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Shipping Dept. Elementary/Secondary (0-12) College (1-4or 5+) Machine Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aben R. Harbaugh Fannie A. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20009 Rosebank Way Hagerstown, Md. 21742 Elaine L. Harbaugh (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Md. 2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) KENKL FAILURE 3 Whs **Physician** /Medical Due to (or as a consequence of): Examiner ARRYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit PNEUMONIA The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown certificate has been signed I rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 1 Inpatient After this 28c. Injury at Work? 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1190 MT AETHA ROMO MD GIMMA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

3 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician September4,2007 1:05 A M Raleigh Ulyess Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson
1 Year | If Under 24 Hrs. Baltimore Gilchrist Hospice If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours MM 2DF Vre Director 247-48-4957 South Car. January1,1928 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐Yes 2 XNo Director Baltimore Maryland Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be r 21204 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must be once. 505 West Towsontown Blvd U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. U.S. Government Cotton Grader 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental F. Alexander Coultria Johnson Pearlie Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raleighetta V. Vannedoe Oglethorpe Hwy. Midway, GA. 31320

Vame of Date | 20c. Location - City or Town, State 8260 E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 X□ Burial 2 □ Cremation 3 □ Removal from State Olanta, South Carolina 4 ☐ Donation 5 ☐ Other (Specify) Jordan Chapel 9/8/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael Margello 6009 Harford Road Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1SCHEMIC CARDIOMY OPATHY **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE
Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): nding physician Physician/Medical the as 1 IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed HUPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy END STAME RENAL DISEASE certificate 25. Was case referred o medical examiner? Be 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Some (Specify) | USP (1 ☐ Yes 2 🔀 📆 P After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the funeral bit of 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760g P.O. Records, Division or Vital

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

DANIEUE DOBERMANIMO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64395

6565 N CHARLES ST. SMITE 216 BALTIMORE, MB 21204

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of	Maryland			nt of H		ind Me	ental Hy	giene Reg. Na 2007	29620
Physic	ian	Decedent's Name (First, Middle								2. Date of Dea	Day Yea	3. Time of Death
/Medi	ical	Estelle Mary 4a. Facility Name (If not institution		nber)		4b. City	Town or	Location of		August	29, 2007	5:25 P M
Exami	ner	Southern Mary					linto					Georges
Funeral		5. Social Security Number		7. Age (In yrs. la		If Unde	r 1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da	th a P	Sirthplace (State or Foreign
Director		577-01-4685 Usual Residence of Decedent	TOM ZUAF	86	Yrs.					Sept.	28, 1920 N	laryland
yiand how		10a. State 10b. County		10c. City	, Town or Lo	cation					· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
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death ms 23	Funerai	7722 Temple Hil	12. Was Deced	dent Ever in U.S	S. 13. V	Vas Dece	dent of His	2074 spanic Orig		ify Yes or No		merican Indian,
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be file tal Hyg	Be	17. Father's Name (First, Middle,									Maiden Sumame)	
y ica	2	Jesse M. Windso			T						Farrell	0050=
ignes 1 and 2 should be filed within 72 hours after death with the Maryland to Heelih and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	1	19a. Informant's Name/Relations Donald R. Kenne		Son								Plains, MD
S 1 en Heel	-	20a. Method of Disposition		20b. Pf	ace of Dispo	sition (Na	me of	I	Da		20c. Location - City	
Peges nent of I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			surrect				9-5-0	07	Clinton,	MD
permit. Peges 1 end Department of Heelth Important; if item 27 eny Injury or other tr		21. Signature of Funeral Service	Lighter MOO	053 01441				s of Facility			ld Washing f, MD 2060	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	aused the death	. Do not ent	er the mo	de of dying	g, such as c	cardiac or	respiratory ai	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	-a. A)	tenos	lers,	No.	CAN	NOION	grun	/sr	PHEATE	Onset and Death
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death death e ette	lcia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregna	rth 2 ∐ Fetal ant at time of de		Ectopic p Other (s	regnancy pecify)				Month	Day Year
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he lav	Completed									24a. Was autor perfo	an 24b. Were prior to death	autopsy findings available to completion of cause of ?
en: T tificet tor, pa	0	25. Was case referred to medica						26 Place	of Death	1 ☐ Yes (Check only o	200 No. 1 Y	es 2 No
hysici nis ce	To B	examiner? 1 ☐ Yes 2 7 No	Hospital:	patient 2 🗆 E	ER/Outpatien	1 3□ D	Othe	· ·			dence 6 □Other (S	Decify)
ing PI		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of (Month)	f Injury h, Day Year)	28b. Time of Injury		28c. Injury Work		1	3d. Describe I	how injury occurred	
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eltar Oliver dinby	Certification:	4 ☐ Homicide determ	ined buildin	ng, etc. (Specify)	eet, ractor	у, опісе		20	City or Tox	Street and Number or wn, State)	Hura) Houre /vumber,
To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours eltar death. To the Funerel Director: After this certificate has been signed by the ettending pl completely filled in by the funeral director, page 2 should be detached for use est	edicai C	29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To the l Examiner: On the ba and manner	sis of examinati	wledge, death ion and/or inv	occurred estigation	at the tim	e, date and pinion, death	d place, ar h occurred	nd due to the d at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certific				29	c. License	number			29d. Date signed (Mo	onth, Day, Year)
		1	P				DI	1943	/		8/30/0	
821		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	7	ns	1#	RT	10/ h ==	6 1 15 200
DO10	ate	31 Date filed (Month, Day, Year)	32	gistrar's Signat	10/ L-1	0100	1/100	141	0/0	20 11.	in grange	00/00/00/99
St Regist	ate trar	31. Date filed (Month, Day, Year)	1 2007	de la	& de	rete						

DHMH 17 Rev 1/2001

			For State Registrar		St	ate of	Marylar	nd / Depa <i>Cel</i>	artment rtificate	t of H ∌ <i>of L</i>	ealth a	and M	lental Hy	giene 2	007	29621
	Physicia		1. Decedent's Name		Last)								2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If			and numb	er)		4b. City, 7	Town, or	Location o	of Death	U		nty of Death	0 11
			Baltimor	e Wash	ington	Medi	cal C	enter			urnie				ne Arı	undel
	Funeral		5. Social Security No		6. Sex			last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir	th V Year)	9. Birthp	place (State or Foreign ntry) TN
	Director		573-96-18		ALZI-IVI	211		51 Yrs.	William		Tiodio		11707	1955	Cour	ÍN .
	land t		Usual Residence of 10a. State	10b. County			10c. Ci	ty, Town or Lo	cation	-					1	10d. Inside City Limits
	Mary -f sh	ţo	MD	Anne A	runde	1		Gamb	rills							1 ∐Yes 2√2No
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	10e. Street and Nun	nber					10f. Zip	Code				10g. Citizen o	of What Cour	ntry?
	th wit	al D	2255 Time	Dr.						210	54				USA	
	ems er m	ne	11. Marital Status		12. W	as Decede	ent Ever in U	J.S. 13. 1	Vas Decede	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 14. F	lace - Americ	
36	s afte	by Ft	1 Never Marrie		ed 1	∐Yes 2y Yes. Give	No		1 □ Yes 2		Specify:	i, i doito	noun, cto.)	Spe	lack, White,	hite
Ö	houn tural' al Ex	q pe	3 Widowed	15. Decedent	Y	ear or Date	es:	16a Dagas	lent's Usual		Al a sa					
. 15	in 72 n "na Aedic	Completed	(Speci	ify only highes	t grade com	pleted)		Give	kind of worl DO NOT use	k done d e retired)	uon <i>uring most</i>)	of worki	ng	16b. Kind of	Business/In	dustry
212	y with giene r tha	mo	Elementary/Secor	ndary (0-12)	C	ollege (1-4 2	or 5+)		inted					Con	struci	tion
2	al Hyler f other vent,	Be C	17. Father's Name ((First, Middle,	Maiden Surn	ame)	
ya.	Ment Ment arked aric e	To	Henry Har	rison K	leen 						Bett	y Os	hiro			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na			rint)		1					l Route Numbe		vn, State, Zip	Code)
. e	1 and Health Pm 27 ther t		Joan Keen 20a. Method of Disp	Wif	e		20h 1	2255					s, MD 2			
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` ≣	artme artme ortant injury		4 ☐ Donation 21. Signature of Fur			-	Me	tro Cre				/28/		Baltim		
Ba	Depar Impor any ir		23a. Part1. Enter th	al p	2 6	1/		12	2 Ridg	gely	Ave.	Ann	desty E apolis,	MD 21		, P.A.
×	Physician /Medical Examiner the priai-transit	dical Examiner	Immediate Cause (F disease or condition resulting in death) Sequentially list condition and the cause. Enter Under Cause (Disease or it that initiated events resulting in death) La	ditions, rediate lying njury	b	Due to (or	as a consequence as a consequence	uerice of):	ARY	A	RES	T				Interval Between Onset and Death
P.O. Box 68	ath certifii attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 1 4 E	Live birth	me pf pregna 2 Feta t at time of d	aldeath 3□	Ectopic pre Other <i>(sp</i> e						Date of delive	ery Day Year
rds, P	w requires that the de been signed by the s should be detached t	<u>ا</u> ۾	Part II. Other signific	- ^	SCONTRIBUTION		but not res	ulting in the un		use giver	n in Part I.			obacco use co ′es 2 No		ne cause of death?
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Vit.	sician: certific rector,	Be	25. Was case referred examiner?	/	Hospita	ıl:				Othor		of Death	(Check only of	ne)		
ō	Attending Physician: r death. ector: After this certifics by the funeral director, t	၉	1 Yes 2 7. Manner of Death	10		a. Date of li	niurv	ER/Outpatient 28b. Time of		`	4 ∐ Nur		ne 5 Resid 8d. Describe h			y)
ion	nding I th. r: After e funer	힐	1 Matural 2 Accident	5 Pending investiga		(Month, I	Day Year)	Injury	М	c. Injury Work? 1 □ Y	es 2∐N		04. D0001100 11	ow mjury occi	uireu	
Vis	or Attendate death Director: in by the	iii	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin		Place of building	injury - At ho etc. <i>(Specif</i>	ome, farm, stre	et, factory,	office		2	8f. Location (S	treet and Nun	nber or Rura.	I Route Number,
	rs after sale or sale or sale or sale or sale of sale	Certification:				building,	etc. (Opecii)	y)				- 4	City or Tow	n, State)		
		Medical	29a. Certifier (Check only one)	Certifying	xamıner: 🔾	To the be in the basis and manner	of examina	wledge, death tion and/or inv	occurred at estigation, i	t the time in my opi	e, date and inion, deat	l place, a h occurre	nd due to the o	cause(s) and r date and place	manner as st e, and due to	ated. the cause(s)
	this property of the property	7	29b. Signature and ti	itle of certifier	1 .				29c.	License		,	2	29d. Date sign	ed (Month, I	Day, Year)
Joye !	104	2	PULL	mx Ki	illuni	\$ M	i)			SA	1336	0			3/27/0	7
0100	UN MA		30. Name and address	ss of person w	no complete	-	death (Item	23a) (Type, F		tw4	, sui	161	34. P)	+SAPE	VA, MI	0-21122
•	Stat Registra	-	31. Date filed (Month	, Day, Year) UG 2 8	2007	32. Fegis	strar's Signa	ture	ريان				(1-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 29622 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Joe Ann Ewell Keyser /Medical 8 28 2007 5:37 A M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9225 Cropper Island Rd. Newark Worcester 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X F Months Days Hours **Director** 218-24-7218 5/26/1928 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified Director MD Worcester 1 ☐ Yes 2 X No Newark 10e. Street and Number 10f. Zip Code a or 10g. Citizen of What Country? ns 23a must t 9225 Cropper Island Rd. Funeral 21841 USA rai", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 2 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced Specify. 'natural", Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Buyer Retail other traumatic event. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 12 should be f h and Mental H marked Charles Calvin Ewell Martha Agnes Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 ages 1 and 2 nt of Health a : If item 27 is Edward Fisher 9225 Cropper Island Rd., Newark, MD 21841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages nent of H Date 20c. Location - City or Town, State injury or permit. Page Department o Important: If any injury or DEBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 8/31/2007 Berlin, MD 21. Signature of Fune Service License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter frie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician onomany disease or condition resulting in death) /Medical Due to (or as a consequence d Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and -tran burial-Due to (or as a consequence of): Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death Month 5 ☐ Other (specify) Dav Year be detached 9 Unknown 9 Unknown þ Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Onknown has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autops this certificate or Attending Physician: 1□ Yes & No 2□No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 30 No Hospital: 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA after death. 27. Manner of Death Certification: 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Injury 2 Accident 1 ☐ Yes the 2 No 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hone (Month, Day, Year) 32. Registrar's Signature

BA 4

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

AUG 3 1 2007

		1	For State of Mary		artment of Healt rtificate of Dea		ntal Hygier Reg. I	2007	29623
Ī	Physicia		Decedent's Name (First, Middle, Last) JOAN CECELIA KINSELI	.A		2.	Date of Death Month SEP 2	2007 Year	3. Time of Death 1:30 PM
9	/Medic Examin	-	la. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENT	ER	4b. City, Town, or Locati			4c. County of Death MONTGON	1ERY
	Funeral Director			n yrs. last birthday) 67 Yrs.	If Under 1 Year If Un Months Days Hou	urs Min.	Date of Birth (Month, Day, Yea	9. Birthp Court 1940 MA	lace (State or Foreign try) ARYLAND
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	vith the N or 28a-i be notifi	Director	MD CHARLES 10e. Street and Number	LA PLATA	A 10f. Zip Code		10g.	Citizen of What Cour	
	ath v	ra	11475 DOBBINS LANE	T	20646		VN	U. S. A.	on Indian
36	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ♥ Perior Vear or Dates:		Was Decedent of Hispanio If Yes, specify Cuban, Me: 1 ☐ Yes 2 ∰No Spe	ic Origin? (Specif exican, Puerto Ric ecify:	y Yes or No- can, etc.)	Black, White, Specify:	etc.
215-003	hin 72 hou e. an "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	i (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b	. Kind of Business/Ind	
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Maryland	should be filed and Mental Hygi s marked other umatic event, t	To B	JOHN WILVER 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	R Address (Street and No			GODDARI	
<u>8</u>	and 2 s ealth ar n 27 is ser trau	1 8	SUSAN P. PAYNE / DAUGHT		75 DOBBINS				· ·
ore,	t is is		20a. Method of Disposition Burial 2 Cremation 3 Removal from State	20b. Place of Dispo		SEPT.	e 20c	Location - City or To	
altimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Dother (Specify) 21. Signature of Fineral Service Licensee	_/	ILL CEM. 2. Name and Address of F	200 Pacility RAY		JITLAND, INERAL SI	MD ERVICE, P.A
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	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SI Due to (or as a condition or substitution or substitution)	EPSIS	ter the mode of dying, suc	ch as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
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68760, <i>⇔</i>	icate be executed physician and s the burial-transit	edical E	d						<u>-</u>
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	w requires that the de leen signed by the should be detached	by	Part II. Other significant conditions contributing to death but r	not resulting in the u	inderlying cause given in F	Part I.	23e. Did tobaco	co use contribute to t 2ሺ No 3 🗆 Prot	
Il Records,	m Q	Completed					24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of 2 1200
Viita	clan: ertific	Be (25. Was case referred to medical examiner?		T	Place of Death (0	Check only one)		
20	Physi this c	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier			5 Residence	6 Other (Specia	5y)
Division or	Attending Physician: If death. ector: After this certification by the funeral director.	ation:	1 XNatural 5 Pending (Month, Day Y 2 Accident investigation	(ear) Injury	Work? M 1 ☐ Yes		u. Describe flow i	njury occurred	
DIX:	al or Attendes after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (- At home, farm, str (Specify)	reet, factory, office	280	f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of the desired process of early manner state.	xamination and/or in					
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,	2		30. Name and address of person who completed cause of dear		1	NATIONA		MEDICAL C	
	<u> </u>	ite	21 Date filed (Month Day Year) 226 Registrar's	MC USA s Signature		DETHEON	A PID ZUC	JUJU - JUUU	
	Regist		SEP 1 3 2007 Mayor	S. A.	este.				

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		_	For State Registrar				tificate of l			Reg. No 2	107	296	524
	siciar edica		1. Decedent's Name (First, Mide Francis Lee	dle, Last)					2. Date of Month AUGUS	Day	Year 2007	3. Time of 410	P M
Exa	mine	d.	4a. Facility Name (If not instituti Baltimore Was	hington Medic	cal Cer		4b. City, Town, or Glen B	urnie		4c. County of Death Anne Arundel			
Fune Direc			5. Social Security Number 219–38–3918									place (State o etry) yland	or Foreign
Aaryland F show			10a. State 10b. Count	e Arundel		Town or Loc	cation a Park				1	0d. Inside Ci	
with the Na or 28a-	2	Director	10e. Street and Number 493 Erin Gar	th			10f. Zip Code		10g. Citizen o	f What Cour	ntry?		
72 hours after death with the Maryland natural, or items 23a or 28a-f show lites Evaminer must be notified at		by runeral	11. Marital Status 1 □ Never Married 2 Ma 3 □ Widowed 4 □ Divorce	12. Was Decedent Armed Forces? 1 12 Yes 2 1	100	0-	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2X No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or lerto Rican, etc.)	No- 14. R B	ace - Americ ack, White, ify: As		
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be be		0 0	17. Father's Name (First, Middle George Lee	e, Lasty						dle, Majden Surn. OWN)			
2 a # 2 5			Jo Ann Lee/W				g Address (Street a Erin Gar			mber, City or Tow Park, MD		•	
S = = C			20a. Method of Disposition 1 ★Burial 2 □ Cremation 4 □ Donation 5 □ Other	n 3 □Removal from State			sition (Name of natory or other plac ans Cemet		Aug. 30	20c. Location	•		
permit. Page Department of Important: If	ouce.		21. Signature of Fureral Service	e Licensee		l Bā	Name and Address PS Gov. R	Sons	P.A. S	everna P everna P	ark Fi	neral	Home
District			23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	or complications that caused st only one cause on each li	d the death.	Do not ente	er the mode of dyin	g, such as card	diac or respirator	y arrest,		Approximate Interval Bett Onset and I	e ween
Physici /Medic Examin	al		disease or condition resulting in death)	a. V 2) Due to (or as	a conseque	nce of):	AR F	ARO		1012	1	LINU	78
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signed by	Ž	2	Part II. Other significant condi	tions contributing to death b	out not resulti	ing in the un	nderlying cause give	en in Part I.		d tobacco use co ☐ Yes 2 PNo		ne cause of d	
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		บ	25. Was case referred to medic	cal				26. Place of I		erformed? s 2 No	death? 1 Yes	2 No	
Physician: r this certific		2	examiner? 1	Hospital: 1 ☐ Inpati	ent 2 EF	R/Outpatient		4 LI Nursin		esidence 6 Co		y)	
or Attending Physician: ifter death. Director: After this certification in by the funeral director.	deiton	Callor	1 ■ Natural 5 □ Pend	ling (Month, Da stigation	y Year)	Injury	M 1	k?`` Yes 2∐No					
Ital or At rs after d ral Direc	orticosticos.		4 ☐ Homicide deter	mined 286. Place of in building, e	tc. (Specify)		eet, factory, office		City or	n (Street and Nur Town, State)			nber,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	locitor	earcar		ring Physician: To the best al Examiner: On the basis of and manner st	of examinatio					ne, date and plac	e, and due to	the cause(s	s)
7576		≥	29b. Signature and title of certif	ier			29c. License	e number		29d. Date sign	ned (Month,	Day, Year)	
			(tun)	Kise, M.D.			101	7///		8/28	1200		
	× V		30. Name and address of person	who completed cause of cause o	death (Item 2	3a) (Type, I	Print) HOSPIA	7/// 19c D	RSVE (8/28/ Sien B	200 2106 KNI	& Mr.	RYUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMENIN TTFM#26 per PHYS 1871 2013/07 WS State of Maryland Peparlment of Health and Mental Hygiene 2007 29625 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25, 2007 ear MARY IRENE LOWE August 11:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1205 Oakwood Drive Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Aug • 29, Year | 926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗹 F Maryland 218.20.6149 81 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Iteme 23a or 28a-f ehow The Medical Examinar must be notified at 1 Tes 2 No Maryland Dorchester Cambridge Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Washington St. 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 M6
If Yes, Give
Year or Dates: 1 Never Married 2 Married δ Specify: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 11 Secretary Furniture Pages 1 and 2 should be filed in nent of Health and Mental Hygic ant: If item 27 ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Medford Willey, Sr. Elizabeth Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Lennox / Daughter 1205 Oakwood Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Desurial 2 Cremation 3 Removal from State Department of important: If eny injury or once. BucktownUMChurchCemetery8.29.2007 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 2) Signature of Funeral Service Licensee ²² Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** recourant MISO Chelions /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consecuence of) Examine physician and s the burial-transit Due to (or as a consequence of) Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 55 Residence 6 Nother (Specify) Residence Daughter's 1 ☐ Yes 2 € No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred 1 ENatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 4 - Homicide

P.O. Records, of Vital spital or Attending Phy nours after death. neraf Director: After this filled in by the funeral o Division To the Hospital within 24 hours a To the Funeral completely filled

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501

SE Frederics

State Registrar 31. Date filed (Month, Day, Year) 1 3 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 24a per dr., g872-10/17/07dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month William McCallum 28 2007 /Medical Examiner Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Jalisbury Kegional Medical enter reninsula 1Camico If Under 1 Year | If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1**X** M 2 □ F 79 Director 454-34-2141 3/12/1928 Texas Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The mountaint if the 27 is anarked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 21801 5827 Bay Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Army Year or Dates: Army 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Duncan A. McCallum Helene Howell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duncan A. McCallum/son 8681 FM 1649, Gilmere, TX 75645 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/29/07 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Agenses 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acuté Henork disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CVD Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed as the burial-transi Exami and Due to (or as a consequence of): 68760 the attending physician Physician/Medical Box IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes PNo P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitai or Attending 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 0063199. 2007

Registrar

31. Date filed (Month, Day, Year) State 0 2007 AUG 3

614 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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EASTERN SHORE DR., SALISBURY, MD, 21804.

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07-06846 Carlene Priscella	Mir	Please Type or Print in Black Indelible Ink. Ensul sser State of Maryland / Department of Health ar	nd Mental Hygiene
Danene Filscella	1	-For State Amended#19aper FH FCHD, Regrifficate of Deathg_	11-07 Reg. No. 2007 296
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle,Last) CARLENE PRISCELLA MUSSER	2. Date of Death 3. Time of Death
pris.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or 1105 Key Parkway Apt. 103 Frederick	or Location of Death 4c. County of Death Frederick
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye Months Da	ear If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ays Hours Min MR, 22, 59 Country) MD,
nd how any	Ī	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location FREDERICK	10d. Inside City Limi
ath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number 1105 Kty PARKWAY APT 103 10f. Zip Code	10g. Citizen of What Country?
	-1	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White, etc. Specify: BLACK
2 hours after "natural", C	최	during most of working li	pation (Give kind of work done 16b. Kind of Business/Industry
1215-0036 dbe filed within 72 hours after dental Hygiene. racked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) / YR BANK TE 17. Father's Name (First, Middle, Last)	LLER BANK INSTURGON 18.Mother's Name (First, Middle, Maiden Surname)
21215- uld be filed Mental Hyg marked of	as l	CHARLES M. D1665 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str	JESSIE SPENCER treet and Number or Rural Route Number, City or Town, State, Zip Code) 2,79
MD nd 2 sho alth and m 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of	
F 5 5 5 4		Bunal 2 Cremation 3 Removal from State PEST HAVEN 1960	M. GARDON SCOT 8 2007 MD. ress of Facility GARY L. ROLLING FUN. HOME
Balti Departition in Juny August 19 10 10 10 10 10 10 10 10 10 10 10 10 10		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	ress of Facility GARY L. ROULING FUN. Home Sound ST PRES bruch MD 2470 I ing, such as cardiac or respiratory arrest, shock, or heart Between Onset a
Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Zol_i idem and ethanol intoxication due to (or as a consequence of):	Death
ecuted and - transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.	
š 5 = =	ledical	XINPENDED AMENDED AMENDED #23a, PII, 27, 28a-f, perME, g872.	10/2/07 TT 23d. Date of delivery
Box 68760, e death certificate be ey the attending physician led for use as the burial	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregnancy Month Day Year
P.O. B es that the de igned by the	ģ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause. Diabetes mellitus	use given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Completed		24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
'ital R sician: T is certific irector, p	Be	examiner? Hospital: 1 Innatient 2 FR/Outpatient 3 DOA	Place of Death (Check only one) Other Other Other: Scene Other: Scene
on of Vading Phy. th. The After this efuneral d	ion: To	27. Manner of Death 28a. Date of Injury (Month Day Year) (Month Day Year)	Injury at Work? 28d. Describe how injury occurred Yes 2 X No unk
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) House	28f. Location (Street and Number or Rural Route Number, or Town, State) 1105 Key Pkwy. A t 103 Frederick
the Hospi in 24 hou in E funer pletely fil	ical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opi	ne, date and place, and due to the cause(s) and manner as stated. inion, death occurred at the time, date and place, and due to the cause(s)
To t with To t	Medical	29b. Signature and title of certifier 29c. Lice	D.C.M.E. 29d. Date signed (Month, Day, Year) September 4, 2007
0		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Balt	l timore, MD 21201
	tate	31. Date filed (Month, Day, Year)	

Registrar

	State of Maryland / Department of Health and Mental Hygien 2 0 0 7 2 9 6 2 1 - State Registrar Certificate of Death Reg. No. 2 0 0 7 2 9 6 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De
Physician /Medical	August Thomas Misunas August Thomas Misunas
Examiner Funeral Director	32 Riverview Avenue Chesapeake City Social Security Number 6. Sex 167-18-7126 Chesapeake City Cecil IVI M 2 F 86 Chesapeake City Chesapeake City Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) 9. Birthplace (State or Fore Country) 1
Aaryiand febow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim Maryland Cecil Chesapeake City
death with the Maryland ms 23a or 28a-f ehow Ir must be notified at meral Director	Maryland Cecil Chesapeake City 10g. Citizen of What Country? 32 Riverview Avenue 21915 United States
21215-0036 ed within 72 hours after death with the Mar ygiene. The maturel', or Items 23a or 28e-1 el tt, the Medical Examinar must by molified Completed by Funeral Director	32 Riverview Avenue 21915 United States
Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other then "naturel", or treumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Restaurant
yland 2 vuid be filed v Mental Hygie arked other atic event, tr	12 Owner/Operator Restaurant 17. Father's Name (First, Middle, Last) Peter Misunas 18. Mother's Name (First, Middle, Maiden Surname) Bessie Shadis
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Marylan pepartment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel; or Items 23a or 28a-1 ehow eny Injury or other treumatic event, the Medical Examinat must be inclifted at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Sue M. Snitcher/Sister 20a. Method of Disposition 1 MB Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Riverview Avenue, Chesapeake City, MD 21915 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Rose of Lima Cemetery 10, 2007 Maryland
Balt Bant Bermit Departit Import Import Enylvi Sure	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Filkton, Maryland 21921 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Conset and Death
760, e be executed xxisitien and e burial-transit cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
S, P.O. Box 687 es that the death certificate sgned by the attending phy be detached for use as the by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)
cords, P. w requires that been signed by should be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the cause of the caus
Il Record The law requir ate has been s page 2 should	24a. Was an autopsy findings availar autopsy performed? 1 □ Yes 2 □ Mo 1 □ Yes 2 □ No
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certificat 24 hours after death. Furner Director: After this certificate has been signed by the attending phy healy filled in by the funeral director, page 2 should be detached for use as the first Certification: To Be Completed by Physician/Meditical	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ft	
TYSE.	30. Name and ddress of per on who impleted cause ideath (Item 23a) (Type, Prin.)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:30 аΜ Robert Eugene Osborn August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens - Riderwood Nursing Home Prince George's Silver Spring 6. Sex If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□ F Months Hours Director 85 September 25,1921 California 559-52-8858 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ortant; If item 27 Is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2KINo Director Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 Jackson Avenue 20912 U.S.A. death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates 1942-1946 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2⊠ No Specify ģ Specify 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed who and Mental Hygier 1 is marked other the Church Administrator Religious 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charley Osborn Ruby Adams 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If item 27 is many injury or other terms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Jackson Avenue, Takoma Park, Maryland 20912 Evelyn D. Osborn - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 09/05/2007 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia Days /Medical Due to (or as a consequence of) Examiner Dys ha ia Years Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ be 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy certificate 2 No 1□ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☒ No ပ 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospita. ... within 24 hours after death.

To the Funeral Director: After a contact of the Funeral Director of the Funeral Director of the funeral part of the 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) D24035 August 28, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 30

2007

E. Machado, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0.0729630 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** ZERHOLTZER, 2040 M WILLIAM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Harwood Anne Arundel Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2∏F 75 Yrs. 535-26-9891 Director Dec. 14, 1931 California Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ehow solcal Examinar must be notified at Maryland Anne Arundel Annapolis 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 Skippers Court 21403 U.S.A. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ty⊟Yes 2 □ No If Yes, Give 1954–65 Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: Specify: White þ 3 Widowed 4 Divorced Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Commercial Airline Pilot Airlines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William E. Oberholtzer, Jr. Lorene Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Oberholtzer/ex-wife 5632 York Place Goleta, California 93117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2x☐€ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Baltimore Crematory 8/29/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20No 3 Probably 4 Unknown been si 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 250No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? stor: After this certifi MANDRIN 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Z မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DQA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 Tyes 2 □No 2 Accident after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number EFENSE HEHWAY ANAPOLIS are NA un 32. Engistrar's Signature 31. Date liled (Month, Day, Year) State AUG 2 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Allen Powell Month 26, aug 2007 /Medical Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Center al-sbare eninsula WIRDMIRS ledica If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) Delaware Social Security Number 8. Date of Birth **Funeral** Days Hours 1**X** M 2□ F 73 9/30/1933 Director 222-18-6280 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Parsonsburg Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21849 USA 7250 W. Ranier Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or DatesAirForce 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) State of Maryland Appraiser h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi and Mental H Ida Carey Clifford I. Powell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 7250 W. Ranier Dr., Parsonsburg, MD 21849 Dolores Powell/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Millsboro Cemetery 8/31/07 Millsboro, Delaware 21. Signature of Funeral Service Vicenses Holloway Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** neprosus) disease or condition resulting in death) /Medical Due to (or a a consequence of) **Examiner** CENTREMON ROPROVED BY MEDICAL EXCHAN Sequentially list conditions, it are cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed use as the burial-trai Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ITYES 2T No Division or Vital Records, P.O. 9 Unknown 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate 2 ☐ No 1□ Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Injury 5 ☐ Pending investigation May 14,2007 Unknown Subject fell To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 E. Carroll St. 4 Homicide Cardiac Rehab Facility Salisbury, MD 11 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar

31. Date filed (Month

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nd address of person ho completed cause of death (Item 23a) (Type, Print)

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32. Jegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hetrick 2007 1:40 PM Doretta 7 Popka September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2550 Kensington Gardens, Unit 101 Ellicott City Howard 8. Date of Birth (Month, Day, Year) April 20, 1912 If Under 2 Hours Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🗙 F 579-12-6668 95 Director Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b County 1 ☐ Yes 2 X No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code pe 2550 Kensington Gardens, Unit 101 21043 United States traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2√2 No Specify. þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Statistician federal government permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If Item 27 is marked any Injury or come. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hetrick Pappenfous Dora ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward A. Popka, son 10539 Hounslow Drive, Woodstock, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 09-10-2007 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART ONGESTIVE 2 YRS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HYPGRIENSIVE Remore Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🗖 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ STENOSIS 1 ☐ Yes 2 X No 3 ☐ Probably 4 Unknown Completed 25 Be 2 27

Physician /Medical Examiner

23a or

or Items

"natural"

marked other than Hygiene.

72 hours after death

Saltimore, Maryland 21215-0036

attending physician and for use as the burial-tran ed by the a detached f signed by t d be detach has funeral After death.

P.O. Box 68760.

Division or Vital Records,

spital or Attendi tours after death. neral Director: A within 24 hours a

Certification:

29b. Signature and title of certifier

PERIPHERM	VASCULAR_	DISCASE.		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
				performed? 1□ Yes 2 X No	death? 1 Yes 2 No			
. Was case referred to medical			26. Place of Dea	th (Check only one)				
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DO	lome 5 Residence 6	me 5 Y Residence 6 □Other (Specify)				
. Manner of Death 1		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred			
3 ☐ Suicide 6 ☐ Could not to determined		ome, farm, street, factory fy)	/, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			
	hysician: To the best of my knominer: On the basis of examina							

29c. License number

042680

To the Hospital

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE NATIONAL RIKE 4C ELLICAT CITY mg 21042

29d. Date signed (Month, Day, Year)

SEPT, 10, 2007

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32. Registrar's Signa

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Type of Fill in black indelible link. Elisare All copies Are Lagible	7	C
State of Maryland / Department of Health and Mental Hygiene	4	7

9633 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9 2007 6:10A M CATHERINE ANN PURBAUGH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY FROSTBURG 120 ARMSTRONG STREET 8. Date of Birth (Month, Day, Year) 9-26-1923 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours MARYLAND 1□M 21XF Director 220**-**16-6604 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28e-1 show the Medical Examination notified at 1 Yes 2 □ No FROSTBURG MD ALLEGANY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 UNITED STATES STREET 120 ARMSTRONG filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 X o If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 ₹ No Specify: Specify: WHITE þ 3 ₩idowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 OWN HOME HOMEMAKER Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tent: If item 27 is marked other toury or other treumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY MONAHAN WELSH ROBERT R. WELSH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 120 ARMSTRONG ST. FROSTBURG, 4D 21532
se of Disposition (Name of Date 20c. Location - City or Town, State 21532 DAUGHTER KAY GAYNOR Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 Cremation 3 Removal from State permit. Page Department o Importent: If any injury or once. 9-12-2007 FROSTBURG, ST. MICHAEL CEM. * 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ST. SOWERS FUNERALHOME, P.A. FROSTBURG, MD 21532 Sowers m∞547 60 w. MAIN Man Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician yeurs COROLAND /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Artuitive Dri secot 1 Yes 2 No 3 Probably 4 Monknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Sidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 5 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after 4 Homicide within 24 hours a To the Funerel C Tip Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ca D21244 9/10/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BROADWAY FROSTBURG, MD 21532
32. Registrar's Signature JESUS H. TAN MD 31. Date filed (Month, Day, Year) SEP 1 3 Maryer D Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September b, **Physician** 2007 8:45 P.M Plunkard Dorothy Jean /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Northampton Manor Health Care Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Say, Year 926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-24-8163 1 M X F 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Frederick 1X Yes 2 □ No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 5955 Quinn Orchard Road Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tes \$ No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public School System Secretery 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Henry G. Stauffer Edith E. Cockrell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Brandenburg/Daughter 602 East Main St., Middletown, Md. 21769 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Mt. Olivet Cemetery Sept. 10, 2007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Fasility Basford Funeral Home 21. Signature of Funeral Service Licenses MQ10021 106 Fast Church Street, Frederick, MD 2170] 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Olastructive Mony la Physician Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown OVOUGE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has by page 2 s autopsy certificate 2 No 1□ Yes : After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 7, 2007 D 22037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 M.D., 610 Ninth Street, Brunswick, Maryland 21716 Leonard C. Kinland, 31. Date filed (Marth Day Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9/7/2007 1:30 P Celbin Moris Pineda-Angel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Kline Hospice House Mt. Airy Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours **™** M 2□ F 19 6/22/1988 Elsalvador Director 220-59-4091 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 21 No Director Frederick MD Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 Elsalvador 9406 Boulder Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1√ Never Married 2 Married Y⊟Yes 2□No Specify: þ 3 Widowed 4 Divorced Elsalvador Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A permit. Pages 1 and 2 should be filed:
Department of Health and Mental Hygis
Important: If item 27 Is marked other: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Angel Mauricio Pineda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9406 Boulder Road Frederick, MD 21702 Mauricio Pineda Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland Injury (Mount Olivet Cemetery 9/10/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee any 106 East Church Street Frederick, MD 21701 MO1176 23. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I ymediate C use (Final di ease or ondition res i in death) **Physician** 21 men 1/2 /Medical s a consequence of): Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of) aftending physician Physician/Medical the IF FEMALE: nse 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Por in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 1 Tes 2 No 1 Dinpatient 2 ER/Outpatient 3□ DOA P this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural death. 2 Accident within 24 hours after death To the Funeral Director:

P.O. Box 68760, Division or Vital Records, To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

5 Pending investigation

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certific

29c. License number

29d. Date signed (Month. Day. Year)

22 Crosswa

31. Date filed (Month, Day, Year) SEP 1 3 State Registrar

3 ☐ Suicide

29a. Certifiei

Medical

4 ☐ Homicide

(Check only one)

Division or Vital Records, P.O. Box 68760 attending physician for use as the buria

Year 09707/2007 4:20 AM Jorge Rodriguez 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 ☐ F 64 568-68-4523 12/17/1942 Salvador Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼No Directo Burke Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22015 9117 Lyon Park Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Vietnam 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1X Yes 2□ No Specify: El Salvadorian Specify: White 2 3 ☐ Widowed 4 🔯 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 'Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government Mechanical Engineer or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Burgos Alejandro Rodriguez ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorge Rodriguez/Son 9117 Lyon Park Ct., Burke, VA 22015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify 09/09/2007 Alexandria, VA Metropolitan 21. Signature of Funeral Se Vice Lice 22. Name and Address of Facility Advent Funeral Services 7211 Lee Hywy, Falls Church, VA 23a. Part . Enter be ti eas shock, or heart failure. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Immediate Cause (Final Physician ZOB SC S 30 06 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner I schamic Coliti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Acuta Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Affect this certificate has been signed by funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 🖂 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DU3998 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nachnan' 8926 Woodyard Rd/#601/Clinton MD 20735 Manach 31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 1 3 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

ellie Shafer		- For State	of Maryland / D	epartmer Certificat			nd Menta	al Hyg		ea No	200	17 2963
Physician		egistrar 1. Decedent's Name (First, Middle,La		2 2					Date of Dea			3. Time of Death
edical Examin	er	Nellie Shafer							Month July 24, 2		Year	0350 hrs
		4a. Facility Name (if not institution, gi University of Maryland Me	·		4t	o. City, Town, o Baltimore	r Location of	Death		4c. Co	ounty of Death	
Funeral	7	5. Social Security Number 6. S		yrs, last birthd	ay)	If Under 1 Ye	ar If Under	24Hrs. 8	8. Date of Bi	rth (MM/DD		thplace (State or
Director		235-46-5517	м 2 Х F 74		Yrs.	Months Da	ys Hours	Min.	02/07	/1933	Foreig Co	m West ^{Juntry)} Virginia
x	-	Usual Residence of Decedent		. City, Town or	Loostin	n						10d. Inside City Limits
low any	- [VA Prince V		Woodbr								1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	ATTITAM	MOOGDI	Tag	10f. Zip Code				10g. Citizer	n of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once		1403 David Court				2219	1			Unit	ed Sta	tes
h with	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.		Decedent of H				D- 14	Race - Amer White, etc.	ican Indian, Black,
er deat		1 Never Married 2 Marrie 3 Widowed 4 X Divorce	1 Yes 2 X	No		Yes 2 X N				Sn	ecify: Wh	ite
urs ath tural"	좕	15. Decedent's Education (Specify	or Dates:		ecedent	s Usual Occup	ation (Give ki				d of Business	'Industry
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f stutraumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	_	ring mo	st of working lif	ician	use retired	1)	To1	ocommit	nications
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215-(e filed v tal Hygi ked oth	Be C		Witt							Conle		
ID 21215-00; should be filed within and Mental Hygiene, is marked other it matic event, the Mec		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing	Address (Str						e, Zip Code)
e, MD 2 I and 2 show Health and P item 27 is nr traumatic		Joy Shafer - I	Daughter Daughter	1	403	David	Court	Woo	dbrid	ge V	irgini	a 22191 r Town, State
5 = 5 = 5			Removal from State	cremator	y or oth	er place)	"			1	-	
Baltimore, permit. Pages 1 a Department of the Important: If ite injury or other trans.	-	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		Pohick		me tery			/2007	_		irginia tle Funeral
Ba perm Depa fmp		Robert G. McColl	lom per DV		Ho	ne, 133	18 Occ	coqua	m Rd.	, Wood	bridge	,VA 22191
Physician	\exists	23a. Part I. Enter the disease, or confailure. List only one cause on		death. Do not	enter th	e mode of dyin	g, such as ca	ardiac or re	espiratory ar	rest, shock	, or heart	Approximate Interval Between Onset and
Medical Examiner	i		a. Acute and Chronic		Hemo	rhage						Death
		Sequentially list conditions,	Due to (or as a consequeb.	erice or).								
	<u>ie</u>	if any, leading to immediate	Due to (or as a consequ	ence of):								
.=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					 -	-		
60, te be executed ysician and burial - transit	흥	LINDENDED	dAMENDED Ite	m 21 pe	- f	h ~971	00/1/	/07 <i>a</i> h	.b.			
50, te be execut ysician and	ledical	UNPENDED IF FEMALE:	23c. If yes, outcome		E 1.	n,go/1,	.09/14/	/U/di	ID	23d.	Date of delive	ıry
Ox 6876(eath certificate attending physe for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fet	al death 3	3 Ectopic	pregnanc	су		onth	Day Year
Box 6876 death certificate the attending phy ed for use as the l	sici	1 Yes 2 No 9 Unknow	4 Pregnant at tim	e of death 5	Oth	ner (Specify)	***					
O. En at the d		Part II. Other significant conditions		ut not resulting	in the u	nderlying caus	e given in Pa	rt I.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		o the cause of death?
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ords w requ	Completed									s an opsy form <u>ed</u> ?		autopsy findings available completion of cause of
Recorder The la	E O								1 Yes	2 ✔ No		Yes 2 No
Vital Reorgician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital:	5 FD(0)			Other	-		Residence	ce 6 Oth	ar:
ing Physi After this funeral dii	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. T	patient ime of li		njury at Work	? 2	28d. Describe	e how injury	y occurred	
on cending ath.	흲	1 Natural 5 Pending) UNKI	10MN	1	Yes 2 🗸	No P	robable r	nultiple f	falls	
Division of Vital Records, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been similed in by the funeral director, page 2 should be	Certification:	2 Accident Investigate 3 Suicide 6 Could not	ot be 28e. Place of Injury	/ - At home, far	m, stree	t, factory, office	e building, et	c. 2	28f. Location or Town,		d Number or F	Rural Route Number, City
Oj spital hours a neral I	S	4 Homicide determin	197 stripy difficient						nknown, ,			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	29a. Certifier 1 Certifying Physone) 2 Medical Examin	ician: To the best of my kiner:On the basis of examin	nowledge, deat ation and/or in	n occur vestigat	red at the time, ion, in my opini	date and pla ion, death oc	ace, and d curred at l	ue to the ca the time, dat	use(s) and te and plac	manner as st e, and due to	ated. the cause(s)
To To com	Mec	29b. Signature and title of certifier	and manner stated.				ense number	32				fonth, Day, Year)
		Allena Krass	(MIX	-		0.0	C.M.E.			Sept	ember 11,	2007
-		30. Name and address of person wh	•		444 🗆	enn Street,	Paltima	, MD 2	1201			
0			Assistant Medical E	Signature	111P	eriii Street,	, Daiumore	=, IVID Z	. 1201			
Sta Regist	rar	31. Date filed (Monts Erry eq.) 4	2007		A STATE OF	3 Ship I						
			•		407							

Registrar

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director.

140

			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
	25. Was case referred to medical	26. Place of Death ('Check only one)		
	examiner? 1 ☐ Yes 2☐ №	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Mursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)		
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	3d. Describe how injury occurred		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	 Location (Street and Number or Rural Route Number, City or Town, State) 		
		sician: To the best of my knowledge, death occurred at the time, date and place, an			

29c. License number

29d. Date signed (Month, Day, Year)

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN J. PUTHUMANA, 3110 GRACEFIELD ROAD SILVER SPRING, MD 20904

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Registrar's Signature

J- Pathumang, MD

State Registra

State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Double Reg. No. 2007 1 - For State Registrar 29640 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** Max G. Sherer 11:30 aM August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Months Hours 1⊠M 2□F New York Director 87 February 26,1920 100-14-2677 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Bethesda Montgomery Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 2 important: or other traumatic event, the Medical Examiner must be note. 20817 U.S.A. 8520 West Howell Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Doctor Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Sherer Sadie Blass ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leah L. Sherer-Wife 8520 West Howell Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King David Memorial Garden's 8/30/2007 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia 21. Signature of Fur and Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Val Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nemon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has e 2 autopsy certificate has rector, page 2 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural within 24 hours after community to the Funeral Director; Af 1 Tyes 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29a. Certifier i <mark>Ճ Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 2 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20850 3 0 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 11 17 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 27, 2007 5:35A. M Maude E. Sparagna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Renaissance Gardens@Riderwood Village Silver Spring Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Sept. 4, 1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** North Carolina 1 □ M 2√2 F 86 245-16-3424 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☐XNo Silver Spring Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number an "natural", or Items 23a or Medical Examiner must be i 20904 United States 3112 Gracefield Road,#122 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int. If Item 27 is marked other than "natural", or Items 23aury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Whi te Baltimore, Maryland 21215-0036 Specify ò q 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Transportation Statistician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys (unk) William J. Meades ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Gracefield Road, #122 Silver Spring, Md. 20904 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Joseph Sparagna -husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 8/30/2007 Crownsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Donald vode Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) years Coronary Artery Disease Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause the conditions of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Examir Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? δ Diabetes Mellitus: Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital Swithin 24 hours after To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D24035 August 28, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.J. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) State 2007 AUG 30 Registrar

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 29642 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dav Year **Physician** Virginia Margaret Steinmann 2007 25 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Annapolis Nursing & Rehab Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 24, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 M 200 213-14-9989 88 1919 Director New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1XXYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 705 Americana Drive, #13 21403 U.S.A. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status e filed within 72 hours after di Il Hygiene other than "natural", or Itam Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 3

Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Receptionist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) : 1 and 2 should be fil Health and Mental H tem 27 is marked ott Be George Clair Mary Mahoney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health ar
Important: If item 27 is: Mary Diane Gossett/daughter 705 Americana Drive, #13 Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Baltimore Crematory 8/28/2007 Baltimore, Maryland 2 Sign ture of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician ARTERIOSCIENOTIC CONSIONASCHAR DISEASE years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown CANDIOMIZO DATAY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Peninheral vascular Disease 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification; 5 Pending investigation 1 Naturai efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours the Funaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ath (Item 23a) (Type, Print) EUNS AURY Rd Hyattsville (U) 31. Date filed (Month, Day, Year) State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lajury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

ospital or Attending Physician: The law requires that the death certificate be executed hours after death. **uneral Director:** After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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	Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death 2. Date of Dea				Reg. No. 2007 29					
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r	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or		of Death	4	c. County		1 1			
	Anne Arundel Medical Center	Annapolis If Under 1 Year If Under 24 Hrs. 8, Date of Birt			Data of Dieth	Anne	Arun				
	5. Social Security Number 219-34-8852 6. Sex XX M 2□F 6.88	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	Date of Birth (Month, Day, Yea pt. 4,]					
	Usual Residence of Decedent 10a, State 10b, County 10c. County	city, Town or Lo	ocation					1	0d. Inside City Limits		
5									1 □Yes 2√√No		
JO .	Maryland Anne Arundel	Gai	Gambrills					10g. Citizen of What Country?			
<u> </u>	2606 Chapel Lake Drive #309		21054					Stat	es		
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0	Joseph Savoca			Helen	DePaula						
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	Melanie Justice / Daughter		Harney R		Little			·	vania 17340		
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	23a. Tr.1. ter the disease, or complications that caused the de shock, or a failure. List only one cause in each line.	ath. Do not en	ter the mode of dyir	ig, such as	s cardiac or re	espiratory arrest,		3	Approximate Interval Between		
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	resulting in death) a. TINON DEPSTS Due to (or as a consequence of):										
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Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribut								he cause of death?		
ed b	Diabetes, Coronary Artery Disease								oably XXUnknown		
plet	24a. Was an autopsy prior							Were auto	e autopsy findings available to completion of cause of		
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Tica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,										
Ser	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)										
Medical Certification:	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
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	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	Dr. Michael J. LaPenta, MD 44	5 Defe	nse Highw	ay A	\nnapol	lis, Mar	yland	2140)1		
е	31. Date filed (Month, Day, Year) 32. Registrar's Sig		land .								
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State of Maryland / Department of Health and Mental Hygiene o

			1 - For State Registrar	State of Maryle	Cer	tificate of i	Death		Reg. No.	2007	29644
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est General Title	Examin	er	4a. Facility Name (If not institution, giv Ravenwood Luthera				r Location of Death CStown			ounty of Death ashingt	on
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9	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Arked other than "natural", or Items 23a or 28a-f show afte event, the Medical Examiner must be notified at	ပ္ပိ	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	e (First, Middle,	Maiden Su		
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•	A		30. Name and address of person who	completed cause of death (I	Item 23a) (Type,	Print)				7/10	
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State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 3 2007

32. Registrar's Signature

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death	Finorial		11. Marital Status	<u> </u>	12. W	as Deceden		l.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Orig	gin? (Speci	ify Yes or No		. Race - Ame Black, Whi		n,
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Atten r deat ector by the	ij.		3 ☐ Suicide 4 ☐ Homicide	6 Could r	ot be	e. Place of it	njury - At h	ome, farm, str	eet, factory, office			f. Location (Number or R	ural Route	Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		29a. Certifier (Check only one)		Examiner:		of examina		n occurred at the til vestigation, in my o							ise(s)
To t Withi To t	Z		29b. Signature and	title of certifie)/	0/1	/	11	29c. Licens	e number			29d. Date	signed (Mon	th, Day, Yea	ar)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 2007 9:30 Рм Martha Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 312 East Second Street If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days 1 □ M 2 1 □ F 220-26-5141 77 Director October 27, 1929 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1KIYes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 312 East Second Street 21701 United States Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☎ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify: White Completed by 3 ☐ Widowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Plot Engineer Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file iment of Health and Mental Hitant: If item 27 is marked oth Be Rebecca DeLaughter Lester W. Boyer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethan Lee Linthicum / Son 429 Banksia Drive, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any injury or o once. September 6, 2007 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory Smithsburg, Maryland .22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service-License M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) of **Physician** 60 CH CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Š signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Pinseles Melli 4 Unknown 1 ☐ Yes 2□ No 3 ☐ Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has 1□ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 3□ DOA 1 Inpatient 2 ☐ ER/Outpatient Certification: To After this 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 040307 asulica 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P Eugene B. Casagrande, M.D. 1564 Opossumtown Pike, Frederick, Maryland 21702-4359

State

Registrar

31. Date filed (Month, Day, Year)

SEP 13

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		tate of	Maryland		artmen rtificate			ind M		Reg. No.		296	47
3	Physici	74	1. Decedent's Name (First, Michael	^{idle, Last)} B rian		Tunney	Y					2. Date of De Month August	Day	2007	3. Time of 7:45	a
	/Medio Examir	37	4a. Facility Name (If not institu	tion, give stree	t and numb	ber)		4b. City,	Town, or	Location o	f Death		4c.	County of Deat	h	
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	Funeral	75.40	5. Social Security Number	6. Sex 1 ½ M		. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da	y, Year)		hplace (State o untry)	
4	Director		216-90-6896 Usual Residence of Decedent			36	115.					1/18/19	971_	Ma	aryland	
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Maryland	0 = 0 5	Be	17. Father's Name (First, Midd Robert Boone		Tr							(First, Middle, n Wille		Sumame)		
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ľē,	s 1 ar f Hea item 3		20a. Method of Disposition			C	lace of Disperent	sition (Nan	ne of			ate		cation - City or	Town, State	
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Division of Vital	ding Physician: The I in. After this certificate he funeral director, page	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident		8a. Date of		28b. Time o Injury		8c. Injury Work	4 📙 NU		ne 5 PResident		6 Other (Spery occurred	cify)	
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	within to the comple	Σ	29b. Signature and title of cer	ffier					. License		٠ ٣.		29d. Dat	te signed (Mont	n, Day, Year)	
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10000	Sta Registr			ar) 0 200	32. 7	gistrar's Signal		barte	,		1			1/ (00)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ownsend 08 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice at comico Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Social Security Number 6. Sex 1 M 2 □ F **Funeral** Months Davs Hours Min. 218-16-5212 83 Director 1924 JAN. 10, MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND PITTSVILLE WICOMICO 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 21850 USA 34650 HEARTLAND DRIVE death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **FARMER** 4 POULTRY permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 Is marked other I any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ WILLIAM TOWNSEND RUTH DONOWAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROBERTA V. TOWNSEND/WIFE 34650 HEARTLAND DRIVE, PITTSVILLE, MD 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) PITTSVILLE CEMETERY 4 Donation 8/30/07 PITTSVILLE, MARYLAND 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Pinn Enter the disease, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Universing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of): attending physician for use as the burial the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 DEctopic pregnancy Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 25. Was case referred to medical examiner?
1 Yes No Be 26. Place of Death (Check only 5ne) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Director:

Registrar

Medical

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifi

DAVID & COURSE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D み 6 2 7 8

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

COASTAL HOSPICE

and manner st

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Thomson Whittaker August 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . **Examiner** Kegional Medical NICOMICO Center eninsula 2alisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month. Dav. Year) **Funeral** Months Hours 1 □ M 2 🕱 F Days 087-14-4224 86 Director 3/25/1921 Connecticut Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 938 James Court 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Boat Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Sterrett Thomson Lois Robinson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Heron Court, Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Jane G. Whittaker/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or otl
once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/1/07 Valhalla, NY Kensico Cemetery 21. Signature of Funeral Service Acensee 22 Holloways funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 days sendo wem branous ENtero colitis /Medical Due to (or as a consequence of): Examiner Due to for as a consequence of: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Hente reval Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy or Vital 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D041211 aug. 28 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Salisbury md 21801 CARROLL 100€. State 3 0 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State RegistraMEND#5, perFH, 9/5/07, DPS, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Phyllis Anne WASSERSTROM Month **Physician** August 26, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6111 Montrose Road #101 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 1167 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕽 F Director April 11, 1929 Wesť Virginia filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at Maryland Montgomery Rockville 1 X Yes 2 No Director 10f. Zip Code 20852 10e. Street and Number 10g. Citizen of What Country? United States 6111 Montrose Road #101 Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No ρ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker Social Work permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofthe any lighty or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Tobin Rose Michaelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7201 Trescott Ave., Takoma Park, MD Amy Wasserstrom, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Tifereth Israel Cemetery 08/29/07 Columbus, OH 21. Signature of Funeral Service License Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner (or consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner burial-tran Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ostemathritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No bowel 24a. Was an Syndrome page 2 s autopsy anxiety + depression 1□ Yes 2□ No

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: funeral director. filled in by

26. Place of Death (Check only one)

Bunian tremur 25 Was case referred to medical examiner? Hospite 1 Yes 2 No

Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

5 PResidence 6 □Other (Specify)

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier womm 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center

61934 8-27-2007 Zeba 5 Geloo, MA Rochille MD 20852 1801 E. Jefferson ST

State Registrar

Certification: To

Medical

31. Date filed (Month, Day, Year)

Health



DHMH 17 Rev 1/2001

within 24 hou To the Fune completely fi

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	Physici /Medi Examir Funeral	cal
60.7	Director	
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

þ Completed

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum **Physician** /Medical Examiner

Examiner burial-transit The law requires that the death certificate be executed attending physician for use as the buria Physician/Medical ed by the a signed by t þ After this certificate has been si funeral director, page 2 should Completed or Attending Physician: Be Certification: To after death Director: filled in by the

Hospital the 0

1. Decedent's Name (First, Middle, Last) 2. Date of Death Merle Gordon Waugh 11:00 P M 2007 August 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel LaCasa Assisted Living 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F 562-24-6500 82 California Feb. 22, 1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Millersville Maryland Anne Arundel 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 1680 Severn Chapel Road 21108 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 N Yes 2 No If Yes, Give Year or Dates: 1943–47 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 ☒ No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NASA Aerospace Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Nordland Charles Rennie Waugh, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1680 Severn Chapel Road Millersville, MD 2 19a. Informant's Name/Relationship (Type. Print)
Dorothy Waugh/wife Ž1108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XICremation 3 ☐ Removal from State 8/29/2007 Baltimore Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Si mallur of Funeral Service Licenson 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Alzheimers Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2 □Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

2 ER/Outpatient 3 DOA

28b. Time of

Injury

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

8 No 3 Probably 4 Unknown 1 ☐ Yes 24a Was an

August 28, 2007

23e. Did tobacco use contribute to the cause of death?

2**k** No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Assisted Living

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 XNatural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

AUG 2 9 2007

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

D052023

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier

25. Was case referred to medical examiner?

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

122 Defense Highway Dr. Maria Romero

Suite 200 Annapolis, MD

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** whaley Imothe 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town, or Location of Death Examiner MD WICOMICO Salisbury Hospice at the Lake If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country),
 f 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) Days Hours 1**⊠**M 2□ F 212-66-0811 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 Xes 2 No MARYLAND Salisburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Winder USA 2180 filed within 72 hours after death v Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) NONE 09 AboRER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WhAlEY JAMES EANE 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WALSON GWEN SISIER Solisbur 11) a HAWARE 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 20a. Method of Disposition €Burial 2 Cremation 3 Removal from State CEM, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility STEWAR FUNERA HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): the attending physician hed for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 27 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Leath 28c. Injury at Work? Certification: Natural
2 Accident (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person

9 200

AUG 2

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29653 State of Maryland / Department of Health and Mental Hygien [7] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 **Physician** Jacqueline Georgiana Shirley Wallace 2ඊරී7 8:25 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1142 Hudson Road Cambridge Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/19/1943 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F 219-48-7992 Director 64 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont If Item 27 le marked other than "naturel", or Items 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Cambridge MD. 1 Yes 2 No Completed by Funeral Director Dorchester 10e. Street and Number 1142 Hudson Road 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21613

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Shirley Jacqueline Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wallace- Spouse 1142 Hudson Road other Cambridge, MD. 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mid Shore Cremation 4 ☐ Donation 5 ☐ Other (Specify) 9/07/2007 Cambride MD 22. Name and Address of Facility Mid Shore Cremation Center P:OBox 1464, 2272 Hudson RD. Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 No 2 No : After this certifica e funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: To 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannes of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the nospector within 24 hours after death.

To the Funerel Director: All investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

OO

31. Date filed (Month Day Ygar) 2007 State Registrar

29b. Signature

and title of certifier

Teal Dr., Suite 2302, Easton, MD 21601 32: Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician in Decoders Name (First Motor Assurance) Physician (Secondary Name (First Motor Assurance) as a consequence of the control of the				1 = For State Registrar	State of Marylar	nd / Departme		Mental Hygie	ene		
Physician Model as Examiner Physician April Color A					ast)	Centilica	ite of Death		16 U U /	29654 3. Time of Death	-
Funeral Directors Social Secury Number S		/Medi	cal	Helen N	1. Yurek	1 4b. Ci	tv. Zow n. or Location of Dea	Month 8	27 6	77 17:288	М
Fundamental Discotory Number 5. Sex 7. Age (in year, ast principles) 1. Mark 7. Age (in year) 1. More 1.		Exami	ier		· Va	hob.	4-11-1	r4	Wico	mico	
100 100				5. Social Security Number 6.	Sex 7. Age (In yrs.	Month		1. (Month, Dey, Y		irthplace (State or Forei Country)	gn
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Specify Spec		or 28a-	irect	10e. Street and Number		101.	Zip Code	10g	. Citizen of What	Country?	_
Specify Spec		23a c	rai D	100			21801		Instea	d States	
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maxlen Sumame) 19. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Purul Route Number, City or Town, State, 20 Code) 19a. Informatic Number of December, Cerematory or other place) 20b. Place of Deposition (Number of December, Cerematory or other place) 20b. Place of Deposition (Number of December, Cerematory or other place) 20b. Place of Deposition (Number of December, Cerematory or other place) 20b. Place of Deposition (Number of December, Cerematory or other place) 20b. Place of Deposition (Number of December, Cerematory or other place) 20b. Place of Deposition (Number of December, Cerematory or other place) 20b. Place of Deposition (Number of December of D	36	irs after de il', or itemi		1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		. 19	Specify Yes or No- into Rican, etc.)	Black, Wi		
The state of the s	2-00	72 hou netura		15. Decedent's 8	Education	16a. Decedent's U	sual Occupation	oduga 16	b. Kind of Busines	s/Industry	_
The state of the s	121	within ane. then	mpie			1	, 1	Van F	and t	FAIR	
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Walter J, well of Disposition (Name of Disposition	ylar	Menta Menta arkad aric ev	To B	Leonard	tondilla		AMAI	YDA H	tilda	NeN	
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22 Signature of Funoral Germon Licensee 23 Signature of Funoral Germon Licensee 24 Signature of Funoral Germon Licensee 25 Signature of Funoral Germon Licensee 26 Signature of Funoral Germon Licensee 27 Signature of Funoral Germon Licensee 28 Part I. Emething (Sease, Or Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or conditions, if any, leading to immediate Cause (Final disease or conditions, if any, leading to immediate cause. Enter Underlying Contain Interest Bermon Licensee 29 Signature of Funoral Germon Licensee 20 Signature of Funoral Germon Licensee 22 Signature of Funoral Germon Licensee 23 Part I. Emething (Sease, Or Complications) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or conditions) interest Bermon Licensee 20 Signature of Funoral Germon Licensee 22 Signature of Funoral Germon Licensee 23 Part I. Emething (Sease, Or Complications) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Impediate Cause (Final disease or conditions) and cause of each licensee and cause of the cause of t		stan Heal Item 2 other	}		20b.	Place of Disposition (A	lame of		c. Location - City	or Town, Stete	Y
23 Name and Address of Eacliffy Physician //Medical Examiner Phys	i	Page ment of ant: ff ury or		* 4 □ Donation 5 □ Other (Spec	ify) Cr	ematory of	Delmatra 8		Delma	, DE	
Physician Medical Examiner Ph	Ba	7		21. Signature of Funeral Service Lice	insee +++			L 927 W		-	
Physician Medical Examiner Medical Examiner				23a. Parti. Erher he disease, or cer	nplications that caused the dea	th. Do not enter the m	ode of dying, such as cardia	ac or respiratory arrest	S Pury,	Approximate	
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitate events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitate events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitate events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitate events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitate events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause (Disease or injury that imitate events resulting in death) Last Due to (or as a consequence of): Due to (or as				Immediate Cause (Final disease or condition						Onset and Death	
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That initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenc	1		ner	Sequentially list conditions, if any, leading to immediate	U	quence of):			· · · · · · · · · · · · · · · · · · ·		_
See at see and the	o,	executed an and rial-transi		that initiated events	c Due to (or as a consec	quence of);					
O C C C C C C C C C C C C C C C C C C C	876	ys e			d						
	Box	death certifis e attending I ad for use as	ician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 ☐ Ectopic				,	
	P.0	d by the	Phys	9 Unknowň		- Main in the condition	Part I	22a Didaha		40 % a course of death?	
	ords,	requires ti een signe rould be c	ted by								m
25. Was case referred to medical examiner? 1 Yes 2 No	II Rec		Comple					autopsy performe	d? prior to	completion of cause of	le
The state of Death Security of	Vita	sician: certific rector,	Be	examiner?	Hospital:		Other				
上 上 月 □ 1 ☑Natural 5 □ Pending □ (Monal, Day Fear) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	o l	g Physer this seral di		27. Manner of Death	28a. Date of Injury	28b. Time of	DUA 412 Nursing			pecify)	
2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	sior	eath. or: Aft	catio	2 Accident investigation	on	М	1 ☐ Yes 2 ☐ No				
28a. Date of Injury All Continuous Co	Divi	ital or Atins after drain Direct	Certifi	4 Homicide determined	building, etc. (Specific	<i>ty)</i>		City or Town, S	State)		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		Hosp 24 hou Funs stely fil	dicai	Check only 2 Medical Exa	miner: On the basis of examina	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner and d	as stated. ue to the cause(s)	
29c. License number 29d. Date signed (Month, Dey, Year)		To the within To the comple	Me	29b. Signature and title of certifier	L as	2	9c. License number	29d	. Date signed (Mo	nth, Dey, Year)	
Q \ (3.50) 7		7) (HUSEK)	4>		1763433	8	130 7		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Up		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)					
State Registrar 31. Date filed (Month, Day, Year) AUG 3 0 2007 32. Figistrar's Signature				31. Date filed (Month, Day, Year)	32. Prigistrar's Signa	ature Angel	',				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5, 2007 **Physician** Bado ptember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Doctor's Hospital Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 24, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ▼F 190-36-9787 92 Dec. Director PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14515 Brock Hall Dr. 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ò 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Elmer Lewis Mary Sampsell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Peters - Daughter 14515 Brock Hall Dr. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Beallsville Cemetery 9-10-07 4 □ Donation 5 □ Other (Specify) Beallsville, PA 21. Signature of Puneral Service Licent 22. Name and Address of Facility Greenlee Funeral Home PO Box 11, Beallsville, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy cate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 222 No death? 1 □ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ပို funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APULIC 300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hosp within 24 ho To the Fune completely f

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 YED ITAQUE TOO Montclaire Que SYED HAQUE 31. Date filed (Month, Day, Year)

emD.

32. Registrar's Signature

and manner stated.

3846

29c. License number

00054636

29d. Date signed (Month, Day, Year)

107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 29657 1- State Amend PI, line c-d, PII, 25, perME, g876-rffi? by of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Helen Marv Brown August 28, 2007 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington NMS Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 21, 19 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Virginia 40 Director 226-06-8086 Nov. 1966 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified 1 ☐Yes 2 ☐ No VA Winchester Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 22601 423 Highland Avenue U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: Black ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lee Roberts Joanne Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Joanne Chambers - Mother 423 Highland Ave. Winchester, VA 22601 Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Omps Crematory 9-1-07 Winchester, VA 22. Name and Address of Facility Cartwright Funeral Home, Inc. 232 E. Fairfax Lane Winchester, VA 21. Signature of Funeral Service Licensee 22601 at Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Physician** /Medical Due to (or as a consequence of): Examiner Cardiac Arrest DN APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The lav requires that the death certificate be executed Anoxic Encephalopathy vears attending physician and for use as the burial-tran Due to (or as a consequence of): CERTIFICAT Division or Vital Records, P.O. Box 68760, Seizure Disorder Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2√☐ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown Urinary Tract Infection 1 ☐ Yes 2 ☐ No Completed Alcohol Leonal 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Abuse 24a. Was an has e 2 autopsy nerform rmed? 2**X** No certific te Drug Abuse To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 _**X**Yes 2X Ne 2 ER/Outpatient 3 DOA 2 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 📉 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0045031 August 29, 2007 30. Name and odress of person who completed cause weath (Item 23a) (Type, Print) 14014 Marsh Pike Hagerstown, MD 21742 Shahab Siddiqui, MD31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07165 State of Maryland / Department of Health and Mental Hygiene
1-For State Amend #1 Per Me C871 97 Earth Cate of Death 2007 29658 John Jay Christen Reg. No. Registrar 2. Date of Death 3. Time of Death John Jay Decedent's Name (First, Middle, Last) Christian Physician/ Month Day Year September 15, 2007 0135 hrs **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3100 Old Frederick Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Mary and 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Country) Director 1 V M 5-15-3056 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County NIA Yes 2 No a ma. 28a-f show must be notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes ac Yes 2 No specify: Specify: If Yes, Give Yeer Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages I and 2 should'be filed within 72 hours, nent of Health and Meinal Hygiene. ant: If item 27 is marked other than "naturi or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) NIA 21215-0036 Never worked 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) rice lita Warren 0 Be nrislian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ave Bacto. md121229 Baltimore, MD mother Abinaton Olita 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Cremation 3 1 Burial 2 Removal from State mem. Park King ron Donation 5 Other Specify 22. Name and Address of Facility 2 21. Signat of Funeral Service Lio 70 FredHILTON Approximate Inter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a art t ster the disease, or complication fail. List only one cause on each line **Physician** Between Onset and /Medical Death a. Multiple Gunshot Wounds Immedi te Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Litter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Records, P.O. þ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? 1 V Yes ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other: A Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 V Yes 2 No 28a. Date of Injury FOUND: 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death Certification: Subject shot FOUND: Natural Yes 2 V No within 24 hours after death.

To the Funeral Director: Pending Director: Sep 15, 2007 0055 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 3100 Old Frederick Road, Baltimore, MD determined (Specify) Bar/tavern 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 15, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month 32. Registrar's Signature 7°2007 State Registrar **OCME**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2007 8:00 PM 12. Sept. Audrev Custy 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Fldercare Center
5. Social Security Number 6. Sex Severna Park
nder 1 Year | If Under 24
ths | Days | Hours | M Anne Arundel 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2XF 218-26-1047 80 March 8,1927 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 24 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21122 U.S.A. 8195 Orchard Point Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ε. Crawford Estelle Schafline Wilmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8195 Orchard Point Road Pasadena, Maryland 21122 Richard Custy (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 9/15/07 Elkridge, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be ပ

Funeral

Director

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

filed within 72 hours after death with the Hygiene.

Baltimore, Maryland 21215-0036

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Division or Vital Records, P.O. Box 68766

To the Hospital or Attending Physician:

certificate funeral director, within 24 hours after death. To the Funeral Director: A

	resulting in death)	a. Due to (or as a conseq		work 5	arres	The grant of the same of the s
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec	uence off:			
lical Exan	that initiated events 'resulting in death) Last	c	uence of):			
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3 ⊟Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
ed by Ph	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlyir	g cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 High
Somplete					24a. Was an autopsy performed' 1∐ Yes 2₩	
Be	25. Was case referred to medical			26. Place of	eath (Check only one)	
ToE	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursin	g Home 5 Residence	6 □Other (Specify)
ation: 1	27. Manny of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fac (y)	tory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Medical Certification:		ysician: To the best of my kno niner: On the basis of examina and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
Me	29h Stonaure and title of artifier		-	29c, License number	. 29d. I	Date signed (Month, Dav. Year)

DHMH 17 Rev 1/2001

State Registrar

30 Name and address of person who completed cause of death

31. Date filed (Month, Day,

29d. Date signed (Month, Da)

D 5 0725

9-13-2

Hwy Millersville M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 THEODORE N. CLARK Sept 12, 2:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7738 Notley Rd. Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠**M 2□ F Months Hours Min. 220 24 9516 81 Director 08/04/1926 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b County "natural", or items 23a or 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if them 23s or 28a-1 show army injury or other traumatic event, the Medical Examiner must be norifited at any injury or other traumatic event, the Medical Examiner must be norifited at Director 1 ☐ Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7738 Notley Rd. 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1945 1 ☐ Yes 2 No <u>Ş</u> Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Bender Clark Juanita Manger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Clark - Son 118 Granada Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 9/14/07 Baltimore, MD 21. Signature of Euperal Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Dr. Pasadena, MD 21122 23a. Part1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 a disease or condition resulting in death) /Medical Due to (or as **Examiner** Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a co physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only on examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ဥ 28a. Date of Injury (Month, Day Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural Accident Injury 1 ☐ Yes 2 □ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 hours after within 24 hours at To the Funeral D

Baltimore, Maryland 21215-0036

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

29c. License number

Certifying Physi; a: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physica: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examin: n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 13Day **Physician** 2007 Charles Roland Crouch Sr. 9:47 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2010 Letitia Ave. Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 4-21-1929 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Hours Min 1 ☑ M 2 □ F 78 217-24-4493 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits X Yes 2 No MD Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2010 Letitia Ave 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. white Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Vending 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry E. Crouch Emma Weissaar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Former Mrs. Gloria M. Hughes/ 203rd St., Pasadena MD 21122 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 9/17/2007 Glen Burnie Singleton Funeral & Cremation Srvc 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M01364 1 2nd Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical FRILLIE Examiner 1 CUTE Ch MILLANTARY Superstially not contained, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed 145/2011011 20 yv1 burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as t IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown VALCULAV Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy SEVEVY 7 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) HOME Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To Hospily 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

CWW.W-

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stewart, mo

29c. License number

29d. Date signed (Month, Day, Year)

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		1 - State Registrar					Ce	rtificate	of D	Death			Reg. No			
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permi Depar Impor any Ir		▶ Lth	Signature of Funeral Service Livensee M00773 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Rd. Odenton, Maryland 21113													112
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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are 1 points. 29663

State of Maryland / Department of Health and Mental Hygiene

			1 - For Stata Registrar	State of Marylar	•	rtificate of			giene Reg. No.		
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	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo				7		10d. Inside City Limits
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Baltimore, Ma	permit. Pages 1 and 2 shoul Department of Health and M Importent: If item 27 Is mari any injury or other treumati <u>once.</u>		Ravenwood Nursing 20a. Method of Disposition 1 Burial 2 Cremation 3 B 4 Donation 5 Dother (Specify) 21. Signa to of Funeral Service Licenses	emoval from State in state	Place of Dispondentery, cremetery, cremetery, cremetery	sition (Name of natory or other place Name and Addre :ate Anate	ss of Facility Omy Board	655 W.	20c. Lo	cation - City or To	
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			30. Name and address of person who co	A KUMAR .	MD	Print) 82(N.	EUTAW	57 #	40 7	7 MD	2/20/
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 2007	32. Registrar's Sigh	ature	Carl Carl					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Olethia Edwards September 8, 2007 10:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Potomac Valley Nursing and Wellnes Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 SyF 492-16-1080 Texas Director 95 Feb. 28, 1912 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville Maryland Montgomery X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1235 Potomac Valley Road 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: Black \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Licensed Vocational Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Scott Sherman Greene Pace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6683 32nd Street N.W. Washington, D.C. 20015 Renee King/Daughter 20b. Place of Disposition (Name of cemetery crematory or other place). Type Ceorge Lown University Sept. 9 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4☑Donation 5 ☐ Other (Specify) Medićal 2007 Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service License 9013 Annapolis Road, Lanham, MD 20706 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Advances /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) signed by the aftending physician and a defacted for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1☐Yes 2☐No 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 N o 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D38262 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd. Suite 330 Anurita Mendhiratta, M.D. Rockville,MD 20850 31. Date filed (Month, Day, Year) 32: Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9 12:45 P M Thomas Theodore Grimm 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 823 Annapolis Road Gambrills Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 10/7/1921 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) 1**X** M 2□ F 85 Director 176-32-1592 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits Gambrills Anne Arundel 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 823 Annapolis Rd 21054 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1. Yes 2 No If **X**es, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>\$</u> 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) military government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Grimm Mary Lazarus ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23421 21267 Hopkins Rd Parksley Mrs. Thomas Grimm Jr./son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation
4 □ Donation 5 □ Other (3 Removal from State Glen Haven Cemetery 9/18/2007 Glen Burnie 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Singleton Funeral & Cremation M01364 Srvcs 2nd Ave SW Glen Burnie MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. po not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Ma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 凝Únknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performe 1 ☐ Yes 2 No 1☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 1 TYes 2 ER/Outpatient 3 DOA this ٩ 7 Residence 6 □Other (Specify) To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending investigation 1 Tyes 2 □ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License-number 29d. Date signed (Month, Day, Year) deress of person who completed cause of death (Item 23a) (Type, Print) Cons 32. Régistrar's Signature 31. Date filed (Month, Day, Year. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 29666 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** William Harrington 5.26 AM 09 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital NA mor If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 6 Say 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min 248-62-0456 72 Director 2-16-1935 S.C. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore 1X Yes 2 No Director Md. NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21213 1628 N. Boardway USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 Specify: 3 Widowed 4 ☐ Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th grade Various Truck Drive 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Christine Pages 1 and 2 should be nent of Health and Mental Blackman ို Harrington Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Harrington, Jr. 2639 Liberty Parkway, Dundalk, Md. 21222 Son Department of Heali Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 9-18-07 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cem. Mt. Dundalk, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 21202 Au 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ndocarditie The law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☑ No 24a. Was an page 2 s autopsy perform P No 1∐ Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician:

ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral I

completely filled 1

(Check only one)

29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29c. License number

29d. Date signed (Month, Day, Year)

Baltimore Mazizoi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar		artment of Health and tificate of Death	Mental Hygiene	007 29667
Physiciar /Medica	Decedent's Name (First, Middle, Last) MARIAN Herbe.	rt		2. Date of Death Month Day Sept. 14	Year 3. Time of Death
Examine		NURSING CENTER	4b. City, Town, or Location of Deat SALISBURY, 1	MD. 21804	ounty of Death WICOMICO
Funeral Director	5. Social Security Number 123–12–0832 6. Sex 1 🗆 M 🚜	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) NJ
the Maryland the Maryland Case fehow cutiling at	10a. State MD Wicomico	10c. City, Town or Lo	Fruitland		10d. Inside City Limits 1 ☐ Yes 21 No
16 IS I A M Is atter death with the Maryland atter death with the Maryland or Items 23s or 28a-f show miner must be inclifted at Elimenal Director	10e. Street and Number 107 Nina Lane		10f. Zip Code 21826		n of What Country? USA
atter or its	1 Never Married 2 Married 1 1 1 Ye	ed Forces? Yes 2 Tho is, Give	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerl ☐ Yes 2 ★No Specify:	to Rican, etc.)	. Race - American Indian, Black, White, etc. pecify: White
21215-003 led within 72 hours lygiene her then "netural", it. the Medical Exp.	15. Decedent's Education (Specify only highest grade comple	(Give life. L	ent's Usual Occupation kind of work done during most of wor OO NOT use retired)	rking	of Business/Industry
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ire, Maryland 21215-003 ife, Maryland 21215-003 s 1 and 2 should be filled within 72 hours Health and Mental Hygiene tiem 27 ie marked other then "netural", other traumatic event, the Medical Exp	19a. Informant's Name/Relationship (Type, Print Darlene Kerr / Daug) hter 107	g Address (Street and Number or Ru Nina Lane, Fruit	ural Route Number, City or T	rown, State, Zip Code) 26
imore, M imore, M Pages 1 and 2 nent of Health int: If them 27 inty or other tri	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Place of Disposementary, crem Redeemer	natory or other place)		tion - City or Town, State
Baltimor permit. Pages Department of Important: If it eny injury or o	21. Signature of Funeral Service Licensee	Moushort 22	Name and Address of Facility Charles L. Steven 501 East Fort Av		me Inc. ore, MD 21230
bhysician and hysician and the burial-transit class Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause (Disease or injury that initiated events cause).	te to (or as a consequence of):	or the mode of dying, such as cardiac	Derece Derece	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 6 for Attending Physician: The law requires that the death certific affect death. Infractor: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as errification: To Be Completed by Physician/Merertification:	in the past 12 months?		Ectopic pregnancy Other (specify)	230	f. Date of delivery Month Day Year
cords, P.(w requires that the been signed by should be detacted by Physical control of the cont	Part II. Other significant conditions contributing	to death but not resulting in the un	derlying cause given in Part I.		contribute to the cause of death?
al Reco The law recate has bee				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital F ilcian: Th certificate rector, pag	25. Was case referred to medical examiner?			ith (Check only one)	
Physic this cral dire		1 Inpatient 2 ER/Outpatient		ome 5 Residence 6	
ding After funer		Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury o	ccurred
5 5 8 5 5	2 Could not be	Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,
To the Hospital within 24 hours a Completely filled	one) and	o the best of my knowledge, death he basis of examination and/or invi manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	rred at the time, date and pla	ace, and due to the cause(s)
or we roo	29b. Signature and title of certifier	7	29c. License number	29d. Date s	igned (Month, Day, Year)
5	30. Name and address of person who completed WILLIAM ROBINS, M.D.		-,	21804	///
State Registrar		2. Registrar's Signature	, DAILDOUNI, FIU.	STOOA	

State of Maryland / Department of Health and Mental Hygiene 9/17/07 Hificate of Death State Registrament #17818 Per Ana Rd C871 Reg. No.2 1. Decedent's Name (First, Middle, Las. 2. Date of Death Month Day **Physician** SEPTEMBER 10.2007 08:05AM Joseph Franklin Howell /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Months Days Director 93 Mar 26, 1914 215-10-1570 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic excessions. 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7700 York Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by Specify. Specify: white 3 Widowed 4 □ Divorced Year or Dates: WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+attorney underwriter legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) -unk-Be G.Robert Howell Grace Turner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Carney/executor 6 Quail Court Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Sign ure Funeral Service Licensee Ronal S Wade. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CLOSTRIDIUM DIFFICILE COLITIS Physician /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s 1☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check onl one Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 3 ☐ DOA 2 ER/Outpatient Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2-elle m.D Schenber 10, 200 D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P MEHTA. M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

	For State	State of Maryla	•			d Mental Hy	giene		
	1 - State Registrar	1	Cei	rtificate of	Death	0.0-4(0.0-4.0-4.0-4.0-4.0-4.0-4.0-4.0-4.0-4.0-	Reg. No. 2	107	29669
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P.	Usual Residence of Decedent						, - ,		
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be filed tal Hyg d other event, i	17. Father's Name (First, Middle, L	ast)			T	Name (First, Middle			
Menta Menta arked atic e	Benjamin Hugh	es			Mauc	le Brannoi	n .		
and 2 should ealth and Mer n 27 is marke er traumatic	19a. Informant's Name/Relationshi	p (Type. Print)	19b. Mailir	ig Address (Street	t and Number o	r Rural Route Numb	er, City or Town	n, State, Zip	Code)
l and lealth m 27 her tr	Vernell Poindex	ter/Daughter	306 A	ragona D	rive, I	Et. Washir			744
Pages 1 nent of H int: If ite iry or ot	20a. Method of Disposition 1	3 Linemoval nom state	cemetery, crei Piedmon	sition (Name of natory or other pla	!	Date	20c. Location	- City or Tov	wn, State
it. Pa Intmer Injury	4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	ecity)	Memoria	LGarden		15-07 Clark S.	Winsto		
permit. Depart Import any Inj once.	21. Signature of Purieral Service L	1.00				rson Ave.			
,vc	23a Par 1. Enter the disease, or o shock, or heart failure. List of	complications that caused the de					-		Approximate Interval Between
Physician	mmedi te Cause (Final disease or condition		scleroti		dis van	alan D.	Con		Onset and Death
/Medical	resulting in death)	a. the to (or as a cons				17.	ruck		$\rightarrow \mathcal{I}$
Examiner	Sequentially list conditions.	b	-111						
executed ial-transit Examiner	Sequentially list conditions, if any, reading to miniburate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equenne of):					= 1	
and and al-tran	that initiated events resulting in death) Last	c	equence of):						
cate be executed physician and the burial-transit dical Examin									
ificate g phys as the		0.							
law requires that the death certific as been signed by the attending p 2 should be detached for use as pleted by Physician/Mer	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg		Ectopic pregnanc	7.		23d. D	ate of delive	ry
e deat ed for sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time o		Other (specify)	, y		M	lonth I	Day Year
that the ed by the detaching	9 Unknown		regulation in the co		una in Dant I	OSo Did	tahasaa waa aar	adaile de de de	e cause of death?
signed the d	Part II. Other significant condition	is contributing to death but not i	esalling in the a	idenying cause gr	ven in ran i.		Yes 2 No	3 ☐ Proba	
v requ									
: The law requil						— 24a. Was	opsy ormed?	prior to con death?	osy findings available npletion of cause of
an: Tificate to par. pa	25. Was case referred to medical				26 Place of	1 Yes Death (Check only	200 No	1 ☐ Yes	2 ⊠ No
hysicis this cert al direct	examiner? 1 ☐ Yes 2√2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	t 3 DOA Oth		ng Home 5 ☐ Res		ther (Specify	<i>(</i>)
ng Ph ter th neral	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Inju Wo			how injury occu		/
eath. or: Al	2 ☐ Accident investiga	ation]Yes 2□No				
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Met	3 Suicide 6 Could no 4 Homicide determin		t home, farm, str ec <i>ify)</i>	eet, factory, office			(Street and Num wn, State)	ber or Rural	Route Number,
spital ours ours and filled	29a. Certifier 1X Certifying	Physician: To the best of my k	nowledge, deat	n occurred at the ti	ime, date and p	place, and due to the	e cause(s) and m	nanner as sta	ated.
the Hosp ithin 24 hou or the Fune ompletely fi		xaminer: On the basis of examination and manner stated.							
within To the Comp	29b. Signature and title of certifier	0		29c. Licens	se number		29d. Date sign	ed (Month, L	Day, Year)
	M 85d-	> m./		O.	5365		09-12	2007	7
2	30. Name and address of person w Mic HAEL Sida ARR San Date filed (Month, Day, Year) SEP 1	tho completed cause of death (If	tem 23a) (Type,	Print)	5 6/1 Acl	ictor Mi	1 20 76	. C	
C	31. Date filed (Month Day Year)	32. Register's Sir	nature	1410/17	KIC1/136	7			
State Registrar	SEP 1	4 2007 Messes	L	Sand .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #27, perME, g871, 9/24/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day, Physician NNSON /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b_City, Town, or Location of Death Examiner OK If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Social Security Number 7. Age (In vrs. last birthday Birthplace (State of Country) **Funeral** Foreig unk Months Days 1 M 2 □ F Feb 4, Director 229-98-7634 Usual Residence of Decedent 10a. State unk 10b. County 10c. City, Town or Location 10d. Inside City Limits show unk unk_{i □Yes 2□No} Examiner must be notified Director 28a-f 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? ō USA or items 23a filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U. lank Armed Forces?
 1 ☐ Yes 2 ☐ No
 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. à Specify: black 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy Injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Medical Center 301 St. Paul Place Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₩Other (Specify) in State 21. Signa un of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street de Director Baltimore, MD 21201 23a. Part I. Enter the dis shock, or heart faild Immediat Cause (Final . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. pproximate nterval Between Inset and Death P Physician XI AU disease or condition resulting in death) /Medical Due to (or as a o seguence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical SATION APPROV IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) o the # 1 ☐ Yes 2 ☐ No. detached has been signed by ge 2 should be detacl σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division or Vital Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page performed? certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Impatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: the Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) Injury Accident 2245 PM 2 107 1 ☐ Yes 2 🕅 No within 24 hours after death.

To the Funeral Director: A Subject Choken 28f. Lo. tion (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide SavaToga Stree restaura. 206 Wi 29a. Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated Medical (Check only one) 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 307

Registrar

State

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** James emper 12,2007 Braz /Medical Facility Name (I) not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner MOVE 0 10 5 UITA N/A If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 □ F Director **MARY LAND** 215-14-3447 82 8-29-1925 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Wes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 3000 HILLIEN RD 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 □ No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No <u>ک</u> Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -8--0-CLERICAL SOCIAL SECURITY marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F Be JOHN JAMES MORIAH THOMAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2: ment of Health ar ant: if Item 27 is GERALDINE JAMES (WIFE) 3000 HILLEN RD. BALTIMORE, MARYLAND 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 11 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) GARRISON FOREST VETERANS 9-19-2007 OWINGS MILLS, MD. funeral Service Lio nsee JON. YTHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signatu 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immerrate Cause (Final disea e or condition Physician resulting in death) /Medical (of as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical the as ase 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate | 1∐ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ို 1 ☐ Yes 2 No 1 Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064546

State

Registrar

DHMH 17 Rev 1/2001

North wolfe St. Balti Move, MO ZIZET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JenKins

07-06974 Richard Knott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ichard Knott		1- For State Registrar State of Maryland / Department of Health and Mental Hy Certificate of Death	rgiene Reg.	No. 200	7 2967			
Physici ledical Exami	.110/		2. Date of Death Month D September 8	ay Year 3, 2007	3. Time of Death 0915 hrs			
		4a. Facility Name (if not institution, give street and number) Sinai Hospital 4b. City, Town, or Location of Death Baltimore		4c. County of Death				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birl Foreig	thplace (State or In Maryland untry)			
id how any:		Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 X Yes 2 No			
th the Maryland 23a or 28a-i sho	Director	10e. Street and Number 10f. Zip Code 21223		Citizen of What Coul Inited Sta	- ·			
hours after death with the Maryland 'naturals', or items 23a or 28a-f sho Examiner must be notified at once	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Fundamental Specify Cuban, Puerto Fundamental	Rican, etc.)	White, etc.	can Indian, Black, ite Industry			
2 3 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Laborer		Construct	ion			
~ ⊏ □ ₽ ∵	To Be Co	17. Father's Name (First, Middle, Last) Richard Bruce Knott, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	Confer		. Zip Code) ೯೪,೧೦			
MD 3 2 shouth and and and with and with and with and with and with and with and with another states of the states		Beth Knott/Wife 1307 West Cross Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	,Baltimo		23			
Baltimore, permit, Pages I am Department of Heal Important: If iten injury or other tra		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligenso 22. Name and Address of Facility Reno	JU /	Odenton, I				
Physician	- 11	2818 E. Baltimore S 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	Street, Ba	ltimore,M	D 21224 Approximate Interval			
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Between Onset and Death			
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	. 3	1.6				
60, ate be executed thysician and te burial - transit	Medical	d. X UNPENDED X AMF, DEDME, g871, 9/17/07 TT / #23a, 27, 28a-f, pe IF FEMALE: 23c. If yes, outcome of pregnancy	erME,g871,	9/21/07 TT 23d. Date of deliver	v			
Sox 687 leath certific e attending p	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) g Unknown	ncy	Month I	Day Year			
, P.O. E res that the d signed by the be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death?			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rasafter death. Therefore the sertificate has been signed by led in by the funeral director, page 2 should be detach	Completed		24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of			
ital Recional The Interpretate	Be	25. Was case referred to medical 26. Place of Death (Check of	Lance Lance					
of Vit ing Physic After this o	P	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing	g Home 5 Re 28d. Describe ho	esidence 6 Othe	r:			
Sion of Attending Phr r death. ector: After ti	Certification:	1 Natural 5 Pending (Month, Day, Yeár) 2 Y Accident Investigation Sept. 7, 2007 5:00 pm	Motorcycli Vehicle Ac	st involved cident	in Motor			
Division pital or Attencours after death teral Director: filled in by the	Sertif	3 Suicide 6 Could not be determined (Specify) Roadway Enfield Rd. & Albans Way Balt						
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	t the time, date an	use(s) and manner as stated.				
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		September 9, 20				
-		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
S Regis	tate trar	1 17 0007 BEE - IN ASSESSED						
	_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day ELIZABETH BARBARA SANTIAGO KEYS September /Medical 14, 2007 1:55 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3739 Courtleigh Drive Baltimore County Randallstown 8. Date of Birth (Month, Day, Year) May 18, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔽 F 94 220-34-5896 Director 1913 Florida Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore County Randallstown 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3739 Courtleigh Drive 21133 Completed by Funeral **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ĭ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph August Santiago ဥ Mary Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Dersch (Daughter) 515 Dunkirk Road, Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 9/17/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signal le of Fun ral Service Vicens 22 Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mentice disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter United Sequences of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2. **M**o 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has After this certificate 1☐ Yes 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 153157-84) 1 Yes 2 No ٦ 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

BBRE

SEP

31. Date filed (Month, Day, Year)

rasprovals

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Sute 400 Cains mills mul 21117

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2007 29674

				Ce	ertificate of	Death		Reg. No.	23014						
	Dhusisia	1. Decedent's Name (First, Midd	fle, Last)			2. Dete of Dee	oth Dey Year	3. Time of Death							
	Physicia /Medica	ULARA JA	NE KUJAWA				Septem	ber 11, 200							
	Examine	An Empilia, Manna (16 mas impais, sin				4b. City, Town, or I									
				laa la at hinthola	If Under 1 Year	Parkvil If Under 24 Hrs.	1e	Baltimore	thplace (State or Foreign						
	Funeral Director	5. Sociel Security Number 219-18-1326 Usuel Residence of Decedent	6. Sex 7. Age (in yrs. lest birthday Yrs.	Months Days		January	9. Birl 26, 1925	Maryland						
	land	10a. Stete 10b. County	/ 1	0c. City, Town or L	ocation		·		10d. Inside City Limits						
	the Marylan 28a-f show notified at	Maryland Balti	more	Parkvi	lle 10f. Zip Code			10g. Citizen of What Co	1 Yes 2 No						
	ath with	8830 Walther B				21234		USA							
21215-0020	urs e	3 ☐ Widowed 4 ☐ Divorce		er in U,S. 13.	Was Decedent of If Yes, specify Cult	Hispanic Origin? (Span, Mexican, Puert	o Rican, etc.)	Bleck, Whit							
4	72 h	15. Deceder (Specify only higher	nt's Educetion est grade completed)	16a. Dece (Give	edent's Usual Occu e kind of work done	ipetion e during most of wor ed)	king	16b. Kind of Business	Industry						
5	within iene. than	15. Deceder (Specify only higher 15. December 15. D	College (1-4or 5+)			9d)									
	a filed v other t	17. Father's Neme (First, Middle	Last)	AGIIIII	istrator	18. Mother's Nan	State of Maryland Name (First, Middle, Maiden Surname)								
Marvland	s 1 and 2 should be filed f Haalth and Mentel hyg frem 27 ie marked other other traumatic event,	Walter Joseph K				Sophie	phie Byczkowski								
2	d 2 should th and Mer 7 ie marke traumatic	19a. informant's Name/Relation	ship (Type, Print)	19b. Mail	ling Address (Stree	and Number or Ru	_	Zip Code)							
	and 2 alth a 27 is	Christine R Kuj	awa Siste	er 8820	Walther	Blvd #350	05 Parkv	ille, Mary	land 21234						
Baltimore	parmit. Pages 1 an Department of Haili Important: if Item 21 any injury or other once.	20a. Method of Disposition XXX Burial 2 □ Cremetion Donetion 5 □ Other (3		Date 9/15/07	20c. Location - City or Baltimore										
=======================================	mit. F sartm sortar r injur	/			Slaus Cer										
<u> </u>	29 E 8 8	renno H	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
		shock, or heert failure. Lis	2014 Style - COI_T												
	Physician /Medical	Immediete Ceuse (Final	/	2.5	da	-									
pm	Examiner	diseese or condition resulting in death)	u	e to (or as a conse		>									
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919	sath certificate be executed attending physician and for use as the bunel-transit	Sequentially list conditions,	Sequentially list conditions, any leading to immediate												
68760	cian a	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events Due to (or as a consequence of):													
87	physic the t	that initieted events resulting in death) Last	at initieted events Suiting in death) Last Due to (or as a consequence of):												
'_ ×	erti		d												
. B	atten			- A Mi i - Ab		in a bank	23b. Did tobacco use contribute to the cause of death?								
= 0	that the death certiined by the attending detached for use a	Part II. Other significent conditi	ons contributing to death but r	not resulting in the i	undenying cause g	ven in Part I.			robably 4 Unknown						
0	as that igned to be det							22							
27.Q. Records	The law requiras that the death cate has been signed by the attence page 2 should be detached for us						24a. Was perfo	rmed?	Were autopsy findings available prior to completion of cause of death?						
2 8	The law ate has page 2						101		1 ☐ Yes 2 ☐ No						
		25. Was case referred to medical	al .	·····		26. Place of Dea	th (Check only o								
		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA	ther: 4 🗆 Nursing H	ome 5 Resid	dence 6 Other (Spe	ecity) Assisted Living						
ر ر	ding Ph. h. After thi funeral	27. Manner of Deeth 1 ☑Neturel 5 ☐ Pendi	28e. Date of Injury (Month, Dey Y	ear) 28b. Time o	of 28c. Inju	ury at ork?	28d. Describe h	now injury occurred							
څ نڅ	Attending of death.	2 Accident invest	igation			Yes 2□No									
Jawa	tal or Attending Pirs after death. el Director: After tied in by the funera	4 Homicide determ	28e. Place of Injury building, etc. (City or Tow	Street and Number or R vn, State)	urei Houte Number,								
12	ospital ci hours a unerei D	29a. Certifier 1 🗷 Certifyin	ng Phyelcian: To the best of n	ny knowledne desi	th occurred at the t	ime date end place	and due to the	ceuse(s) and manner e	s steted.						
3	n 24 hound no Euror	(Check only 2 Medical	Examiner: On the best of examiner state												
-7-	To the Hospital or Att within 24 hours after of To the Funerel Direct complataly filled in by	29b. Signature end title of certifier 29c. License number						29d. Date signed (Mon	th, Dey, Year)						
		1 mm			115	86412		Sentencia	(12 2007						
	5	30. Neme end eddress of person	who completed cause of deat	h (Item 23e) (Type	, Print)	-0.6		hicanose							
(J	Anna Mon	195 4500	wal.	ther	Boulera	w Pa	sleville, o	C 12 2007						
	State	OFP 7	32. Registrer's	Signature	ADP . A			,							
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			State of Maryla	nd / Departm <i>Certific</i>	ent of Health ar ate of Death		gien 2 0 0 7 Reg. No.	29676
	Physician	Decedent's Name (First, Middle, Last	2 (2. Dete of De Month	Dey Year	3. Time of Deeth
	/Medical		rduen Len	J\3		Septem	her 12 200	
	Examiner	4a Fecility Name (If not institution, give			4b. City, Town	n, or Location of Deat	4c. County of Dee	eth
		Augsburg Luther	7		Loche	arn	Baltim	
	Funeral	5. Social Security Number 6. S	ZM OFF	Mont		Min. (Month, Da	iy, Year) C	rthplace (State or Foreign ountry)
3	Director	245-20-2193 Usuel Residence of Decedent		79 Yrs.		4-9-	1928	N.C.
	dand	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	Mary Firsh tor	Md. Baltin	nore	Lochearr	1			1 □ Yes 2√□ No
	r 284 Lnot	10e. Street end Number			Zip Code		10g. Citizen of What C	ountry?
	hwit 23a o Bi D	6811 Campfield	Rd.		21244		USA	
	after death with the Ma r items 23a or 28a-f s inher must be notified Funeral Director	11. Meritel Stetus	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was De	ecedent of Hispenic Origin specify Cuben, Mexican, F	? (Specify Yes or No	- 14. Raca - Am	
0	or he maker	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ No If Yes, Give		s 25 No Specify:	dorto i ficari, etc.)		•
21215-0020	filed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural; or items 23a or 28a-f show ant, the Medical Examinat must be notified at a Completed by Funeral Director	3 Widowed 4 Divorced	Yeer or Detes:		ZANO Opeany.			lack
7	natu	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a. Decedent's L (Give kind of	work done during most o	f working	16b. Kind of Business	/Industry
7	withir ene.	Elementary/Secondary (0-12)	College (1-4or 5+)	Inte. DO NO	T use retired)		Israel Ba	apt. Church
42	offied vorter the vent, th	12th grade 17. Fether's Neme (First, Middle, Last)		Eng	ineering	Name (First, Middle		2 <u>P</u> C - 0.102 - 1.
an	Mental Hygi arked other atic event, I	Emmauel	М.	Lewis				
Maryland	4.2 should be filed within the and Mental Hygiene. 7 is marked other than traumatic event, the Maramatic event.	19a. Informant's Name/Relationship (7		1	ess (Street end Number of	sephine	Par	
Z	nd 2 sho alth and 27 is me	Angela Satchell	Daughter		ourwood Ct.,		-	
a,	<u>~ # = 2</u>	20a. Method of Disposition	20h	Plece of Disposition (Neme of	Dete Dete	20c. Location - City or	
2	ages ant of t: If if y or o	t☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	memoval from State	cemetery, crematory		9-21-07	Ordner Mi	11- wa
Baltimore,	parmit. Pages 1 Department of F Important: If ite any injury or of	21. Signeture of Funeral Service Licens			and Address of Facility	March F	Owings Mi	IIS, MQ.
B	any gang	1 Lemon m	1	1 4/	Ol E. North			21202
	TO STATE OF THE PARTY.	23a. Pert1. Enter the disease, or compshock, or heart failure. List only of	dications that caused the dea					Approximate
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a		hysema			Interval Between Onset and Death
	death certificate be executed e attending physician and ed for use as the buriat-transit sician/Medical Examiner	Sequentially list conditions.	b. Due to (or as a consequenca	of):			
ő	ian a	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury						1
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Вох	ath c for us							
o.	that the death ed by the atte detached for / Physicia	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	ig cause given in Part I.			e to the cause of death?
Δ.	es that it igned by be detac by Ph					1734	Yee 2∐ No 3∐ P	robably 4 🗆 Unknown
Vital Records,	requir been s should					24a. Was	an autopsy 24b.	Were autopsy findings available prior to completion of cause of death?
æ	The law ata has paga 2					101	res 203 No	1 ☐ Yes 2 ☐ No
ita	certificata rector, pag	25. Was case referred to medical			26. Place of	Death (Check only of	one)	
	Physician: this certific ral director, TO Be (examiner? 1 ☐ Yes 2 de No	Hospital: 1 ☐ Inpatient 2 ☐	I ER/Outpatient 3□	DOA Other: 418 Nursi	ing Home 5 ☐ Resi	denca 6 □Other (Spe	ecify)
n of	ding Ph h. After th funeral	27. Manner of Death 128 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe	now injury occurred	
<u>.</u>	Attending or death. ector: After by the fune	2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	М	1 ☐ Yes 2 ☐ No			
Division	lal or Attending P is after death. si Director: After ted in by the funer; Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Injury - At h building, etc. (Special	ome, ferm, street, fac	tory, office	28f. Location (City or To	Street and Number or R vn, State)	ural Route Number,
	ital or irs after rai Dir lled in					a la		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director, Medical Certification: To Be (29a. Certifier 1 ← Certifying Phy (Check only one) 2 ☐ Medicat Exami	sician: To the best of my kno ner: On the basis of examine	owledge, death occurretion end/or investigat	ed at the time, date end p ion, in my opinion, death	place, and due to the occurred et the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	thin 2 the omple	29b. Signeture and title of certifier	end manner steted.		29c. License number		29d. Date signed (Mon	th. Dev. Year)
	with To Con	>					- 1	e 13,2007
	1.1	20 Normand		- 00-) /T 2 : · ·	D3757		2. hisma	0 13,000 /
	611	30. Name end address of person who co	MD 25 M		Reisterst	own MI	21136	
	State	31. Dete filed (Month, Day, Year)	32. Registrar's Signo		Por 31 4 31	J. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	01136	
- T	Registrar	SEP I	7 2007 Danies	JE AD	Store of			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** James Benton Lippy 12:13p M September 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Health Center Bel Air If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ₹ M 2 □ F 212-50-1121 60 Director Jan 15 1947 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medikal Examiner must be notified at once. Sykesville MD Carrol1 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21784 114 Heritage Lane Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 NYes 2□ No Vietnam If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Adm. Elementary/Secondary (0-12) College (1-4or 5+) +4 Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred LeBrun Robert Lippy ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Heritage Ln., Sykesville, MD 21784 Linda Lippy (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD All County Cremation 9-15-07 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Dage Haight Ferbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myocardia /Medical Due to (or as a consequence of): **Examiner** disease Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) pulmonary disease obstructive hronic Due to (or as a consequence of) attending physician for use as the burial intolerance Physician/Medical glucose IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 2 No 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 040365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapanke Dr. Belair, MD 21014 ente 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Budgett.

			For State Registrar	State of M	•	epariment o Certificate d	r Health and of Death		IENE eg. No.		
	×	¥	Decedent's Name (First, Middle,	Last)				2. Date of Deat	th	3. Time of Death	
	Physici /Medic		William	Land	ress			Month Septemb	Day Year er 14 200°	7 551 PM	
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or Location of Death		4c. County of Dea		
	-		Northwest to				Lailston		Baltim		
40	Funeral Director	tor	Months Days Hours Min. (Month,						Year) 9. Bir Co	thplace (State or Foreign ountry) Georgia	
	be filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
			MD Balti	more	Owing	s Mills				1 ☐ Yes 2 No	
21215-0036		irec	10e. Street and Number			10f. Zip Coo	de	1	0g. Citizen of What Co	ountry?	
		a D	5114 Wagon She	d Circle		211	17		U.S.A.		
		To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No	13. Was Decedent If Yes, specify €	of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi Specify: W		
5-0			15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual Oc (Give kind of work do	ecupation one during most of we tired)	orking	16b. Kind of Business	/Industry	
2	ithin ne.		Elementary/Secondary (0-12)	College (1-4or	5+)				0 0 4 / 34	1.	
12	should be nd Mental marked o		17. Father's Name (First, Middle, Li			Branch Ch		ame (First, Middle, I		edicare	
Maryland			Robert Landres					r Parker	,		
ary.			19a. Informant's Name/Relationshi	(Type. Print)	19b.	Mailing Address (St			, City or Town, State,	Zip Code)	
	1 and 2 s Health ar em 27 is		Patricia Landr	ess Wi	.fe 51	14 Wagon	Shed Circ	le, Owing	s Mills, M	D 21117	
Baltimore,			20a. Method of Disposition	Domougl from State	20b. Place of cemeter	Disposition (Name o	f place)	Date	20c. Location - City or	Town, State	
Ë	πit. Page lartment o ortant: If Injury or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (<i>Spe</i>			Valley M	em. Gds. 9		Timonium,	MD	
alt	permit. Pages. Department of Inportant: If Ite any Injury or of		21. Signature of Funeral Service Li	pensee/	11.	22. Name and A	•		Reisterstow		
ш	80 = 99		COUN	man	Su		NERAL HOME		stown, MD		
0	Physician / Medical Examiner physician and stree private physician and stree private physician and street physicia		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each I	d the death. Do n ne.	ot enter the mode of	dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)	_ u.	reumo						
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oʻ	exectan an		Due to (or as a consequence of):								
68760,	ate be hysici the bu	y Physician/Medical	8	d							
	ertifica ling pl		IF FEMALE:	000 16							
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						livery Day Year		
										o the cause of death?	
ord		ed	Al 2 heiners Dementia 1 Yes 2 No 3 Probably 4 Junk							robably 4 Unknown	
or Vital Records,		Completed by	Alzherners Dementia 1 Yes 2 No 3 Probat Coro nany artery disease 24a. Was an autopsy prior to comp death? 1 Yes 2 No 1 Yes 2						utopsy findings available completion of cause of		
/ita		Be (25. Was case referred to medical examiner?					eath (Check only on			
or o		2	1 Yes 2 No No No National 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)								
nc		Certification:	27. Manner of Death 1	(Month, Da	8a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d		28d. Describe no	d. Describe how injury occurred			
Division		licat	3 Suicide 6 Could no	t be 28e. Place of in	jury - At home, far	m, street, factory, of		28f. Location (Si	treet and Number or Fi	ural Route Number,	
<u>S</u>		erti	4 Homicide determin	building, e	tc. (Specify)	(Specify) City or Tòwn, State)					
		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Lio	cense number	2	9d. Date signed (Mon	th, Day, Year)	
	2			1	40	D	00661	11	Septembe	r 14 2007	
5			30. Name and address of person w	ho completed cause of		Type, Print)					
Jessa Edelman MD											
	State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature										

DHMH 17 Rev 1/2001

07-07052 Carla Barber Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 29679

	1- For State Certificate Registrar Certificate	e of Death	2001 2301 Reg. No.					
Physician ledical Examine	Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year 4750 to					
nedical Examine	Carla Barber Lee 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	er 10, 2007 1750 nrs 4c. County of Death					
	Sinai Hospital	Baltimore						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	,,	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign					
Director	219-96-8320 1 M 2/F 29 Yrs. Jan. 10, 19 18 Country) Merylane							
ang.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits					
*	Maryland NIA Bala	t, more	1 Yes 2 No					
the Maryland or 28a-f show iffed at once.	10e. Street and Number		10g. Citizen of What Country?					
th the Maryland 23a or 28a-f sho notified at once	2000 0 10101 11011	3. Was Decedent of Hispanic Origin? (Specify Yes or N	Un 1 fed States					
72 bours after death with the Maryland n"natural", or items 23a or 28a-f she al Examiner must be notified at once peted by Eumeral Director	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.					
s, after de	3 Widowed 4 Divorced If Yes, Give Year	Yes 2 No specify:	Specify: Black					
"natural" E amine		edent's Usual Occupation (Give kind of work done ng most of working life. DO NOT use retired)	16b. Kind of Business/Industry					
5-0036 ed within 72 bour lygiene. other than "natt he Medi-al Evan	Elementary/Secondary (0-12) College (1-4 or 5+)	·NE	NONE					
		18.Mother's Name (First, Middle	Maiden Surname)					
2121 2121 Mental F Marked ic event,		lailing Address (Street and Number or Rural Route Nu	ouglas					
MD 21 d 2 should the and Me n 27 is ma tumatic ev			Hinora Maryland 21215					
C 65 E 79	20a. Method of Disposition 20b. Place of D	isposition (Name of cemetery, Date or other place)	20c. Location - City or Town, State					
Baltimore, Department of He Important: If ite	1 Burial 2 Cremation 3 Removal from State crematory 4 Donation 5 Other Specify:		Balternove MD					
Balti permit Departn Imports injury	21. Soft ture of Funeral Service Licensee	22 Name and Address of Facility (L4) Aggs	FS. P. A.					
Physician	23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva							
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a Pulmonary Thromboembolism Between Onset and Death							
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on of \nding Phyth. th.: After the funeral	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	s now injury declared					
r Atter r Atter ter dea irector n by th	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		(Street and Number or Rural Route Number, City					
Division or spital or Attending spital or Attending sours after death. neral Director: After filled in by the funer	4 Homicide determined (Specify)							
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
To the He within 24 To the Fu completel	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	Tal Mist	O.C.M.E.	September 11, 2007					
	30. Name and address of person who completed cause of death (item 23a)							
ð	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Stat Registra	(SPEE) 7 /7 /2007 Fee 07 07 07 07 07 07 07 07 07 07 07 07 07	selle?						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 For State Registrar Amend 20b&c, perFH, C871, 9/19.07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 10, 2007 Physician JOAN TOUEY LAKE 10:33P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST. JOSEPH MEDICAL CENTER Towson Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 23, 19. 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In vrs. last birthday) Months Days 1 □ M 2 🛣 F Yrs. 71 159-30-6598 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Director Maryland Baltimore County Timonium 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 2328 Eastridge Road 21093 Funeral **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Property Manager yrs Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Joseph Touev Elsie Gladys Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2328 Eastridge Road, Timonium, Maryland 21093 Benson Lake (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. Veterans Cemetery

Dilaney Valley M. Tamlens

9/18/2007 20c. Location - City or Town, State **Timonium** 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Garrison, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of a Funcial Save Und source M? Name and Address of Facility M? TCHEIL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ENBOYOVESEUST 1/123222 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other Ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 126919 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perfor VENIO SERVES: 5 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation

Box 68760, SEPTEMBER P.0 Records,

be exec as the this

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienne Important: If Item 27 is marked other the any injury or other traumatic event, the ones.

Physician /Medical

Examiner

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Division or Vital Hospital or Attending Physician: after death filled in by 24 hours a ompletely within 2 To the

State Registrar

Medical

EDDIE NAKHUDA, M.D.

6 ☐ Could not be

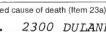
2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

29d. Date signed (Month, Day, Year) .07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 32. Registrar's Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

Shude

		State of Maryland / Department	artment of Health and I TH tificate of Death	Mental Hygien	2007 29681
Physic		1. Decedent's Name (First, Middle, Last) William Hamilton Lee, Sr.		2. Date of Death Month 9/11/20	3. Time of Death 11:00 P ^M
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl		Ic. County of Death
		201 Haile Avenue	Brooklyn Par	k	Anne Arundel
Funeral		5.216-48-0930 6. Sex 7. Age (In yrs. last birthday) 216-48-0930 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 4 / 5 / 194	9. Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent		4/5/194	7 Maryland
/land ow at		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
Man a-f sh ified	tor	MD Anne Arundel Brookly	yn Park		1 ☐ Yes 2 M No
with the Maryland a or 28a-f show the notified at	Director	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Country?
ath w		201 Haile Avenue	21225		USA
aryitating ZIZI3-VU30 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. in marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Married 1. □ Yes 2. No.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
hours af tural", or	by	1 ☐ Never Married 2 M Married 1 ☐ Yes 2 ☐ Mo If Yes, Give 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No Specify:		Specify: White
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laryland CICI 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last) Henry Lee		ne (First, Middle, Maide A. Dills	*
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IOCE, INTELYIS ges 1 and 2 should nt of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Dispo			Location - City or Town, State
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Dartinore, permit. Pages 1 ar Department of Hea Important: If item any Injury or othe once.		21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility ${ m H}_{ m L}$	ubbard Fu	neral Home Inc
0 89E 8 8		Tilan Omber 41	07 Wilkens Avenue	e, Baltimor	e, Maryland 21229
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/Medical Examiner		Due to (or as a consequence of):			
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2 s		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place	i e, and due to the cause	(s) and manner as stated.
n 24 h he Fu he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occi	urred at the time, date a	and place, and due to the cause(s)
To t To t	ž	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		1 400 (NOW)	1 141360		99-14-2007
50		30. Name and address & person who completed cause of death (Item 23a) (Type,	Print) Baid		10 21215
	ate	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	1/14(1)	(-	(1) -1-/3
Regist		SEP 1 4 2007 1 4 60	we		

07-06981 Lamont Marcus Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	uneral	ļ		X M 2 F	37	Yrs. Mon				Foreig	
	any		10a. State 10b. County	1	Oc. City, To	wn or Location					10d. Inside City Limits
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- Jane	or 28a-f sho	Director	10e. Street and Number			10f. 2	ip Code		10g	. Citizen of What Cour	
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į	", or i		21	1 Yes 2x	No	1 Yes	2 X No specify.	:		Specify: B	lack
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215-0036	e nied tal Hy; ked ot nt, th	Be C	Alfred Marcus					y Gib		,	
72	Pages 1 and 2 should be filed within 7, ment of Health and Mental Hygiene. fant: If item 27 is marked other than or other traumatic event, the Medical	P	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing Addre	ss (Street and Nur	mber or Rurat	Route Number	er, City or Town, State	
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Baltimore,	t. Pag tment rtant:		4 Donation 5 Other Spec		Arbu	itus Men	norial	9/17	/07	Arbutus,	Md
Bal	permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum:		21. Signature of Funeral Service Lic	MANAM		14300	nd Address of Facility F/H We Wabash	Ave,	Balti	more, Md	21215
/N	ysician /ledical		23a. Part I. Enter the disease, or co failure. List only one cause on	mplications that caused the each line. UCCLUSING a. Complications of	ne death, Do re pulm	onot enter the mod conary thron	e of dying, such as on nboemboli wi	th pulm	piratory arres Onary in	nt, shock, or heart nfarction	Approximate Interval Between Onset and Death
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of i	ing Phy After th uneral	-	27. Manner of Death	28a. Date of Injury (Month, Day,Yea	/ 28	8b. Time of Injury	28c. Injury at Wor	k? 28d	. Describe ho	w injury occurred	
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. ت	lospita 4 hours unera ly fille	0	29a. Certifier	(Specify) sician: To the best of my	knowledge	death occurred at	the time, date and o	lace, and due	to the cause	(s) and manner as sta	ted.
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f	1 X 1 X E 8	Me	29b. Signature and title of certifier	and mainer stated.			29c. License numbe	г		29d. Date signed (Mo	
	10	Ę	/ ///				O.C.M.E.			September 10, 2	2007
	0616	•	30. Name and address of person will Mary G. Ripple MD.	ho completed cause of de Deputy Chief Medica			ın Street, Baltin	nore, MD 2	21201		
	S	tate	24 Date filed (44 -th Day Varia)	32 Registrar's	s Signature						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

Certificate of Death Reg. No. 29683 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARTIN SEPTEMBER : 43 Am 14,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner BALTIMOR HARBOR HOSPITAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Social Security Number **Funeral** Days Months Hours 213-30-7173 1 M 2 □ F 72 12-21-1934 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b, County 1 Yes 2 No Director Maryland n/a Baltimore 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a or United States 1234 Patapsco Street 21230 Apt. 7 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ht. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Meat 5 years n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia B. Miller John C. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1234 Patapsco St. Apt. 7 Baltimore, MD 21230 Lorraine Martin (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXeurial 2 □Cremation 3 □Removal from State Cedar Hill Cemetery 9-18-2007 Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funda Service Lice McCully-Polyniak Funeral Home, P.A. Wayne Osterling 130 E. Fort Ave. Baltimore, MD 21230 Approximate Interval Between Onset and Death se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Immediate Caus Trnal disease or condition resulting in death) Physician DAYS INTRACRANIAL HEMOFFHAGE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated except Due to (or as a consequence of) attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending To the Hospital or Attendir within 24 hours efter death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOI SEPTEMBER 14,2007

State Registrar

DHMH 17 Rev 1/2001

-JEGAYEHU

EFE-GIFAWOSSEN 31. Date filed (Month, Day, Year) Bloom &

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE, MARYLAND 21225 3001 HANDVER STREET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

29684

			1 - For State Registrar		,	Certif	icate of L	Death	Re	eg. No.	
	Dhusia		1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medi	•	JOSEPHINE PO	INTER	MULLIN				Septemb	er 13, 2007	7 6:45 P. M
1	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b	. City, Town, or	Location of Deat	h	4c. County of Death	1
			Blakehurst				Tows	-		Baltimo	re
	Funeral Director		232-32-0932	ex 7. Age □ M 2∑ F	(In yrs. last birt		Under 1 Year onths Days	Hours Min.		Year) Con	place (State or Foreign intry) SISSIPPI
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on				10d. tnside City Limits
	Manyl 1 ehc	ō	Maryland Baltimo	ore	Тс	wson					1 ☐ Yes 21 No
	the 1	rect	10e. Street and Number	ore	1.0		Of, Zip Code		11	0g. Citizen of What Co	intry?
	3a or	Funeral Director	1055 W. Joppa Ro	oad				1204		U.S.A.	•
	deatl	ner	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was	Decedent of His	spanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Amer	ican Indian,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-1 show enty injury or other traumatic event, the Medical Examinar must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	0	_	s, specify Cubar Yes 2∭X No	Specify:	to Hican, etc.)	Specify: Wh	
20	72 ho	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent	s Usual Occupa	tion uring most of wo	rkina	16b. Kind of Business/I	ndustry
7	ithin	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5+	·)	life. DO I	VOT use retired)	, , , g , , , o , , , o	9		
2	led w lygier her th			2 years		Hon	emaker			Own Home	
E C	be fi	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middle, M	Maiden Sumame)	
ž	Mer Marke Maric	ဥ	Clem Joseph Po							on Nicols	
ā	12 sh and 7 le n		19a. Informant's Name/Relationship (_				City or Town, State, Z.	
Ġ.	1 and 1ealtl am 2		Randall S. Mullin 20a. Method of Disposition	(son)	20h Place of	L8 Mt	. Royal	Terrace		ore Maryla	
و	i if it		1 X Burial 2 ☐ Cremation 3 X		1		n (Name of ry or other place				
Ξ	rtmer rtent njury		4 Donation 5 Other (Specify		Riverd	lale (Cemeter	y 9-2	1-07	Columbus, G	eorgia –
Ba	Depa Impo eny i		21. Signature of Funerat Service Licen	rem		Mit 65	chell-W 00 York	iedefelo Road	i Funeral Baltimore	Home, Inc , Maryland	21212
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only	plications that caused to one cause on each tine	he death. Do n	ot enter th	e mode of dying	, such as cardiad	or respiratory arre	est,	Interval Between
4	Physician	0 1	tmmediate Cause (Finat disease or condition	Carcin	wa n	rette	tritie	6/1vez	unterior	N PRINARU	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o			,		'	
	Examiner		Sequentially list conditions.	b							
	D ii	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence o	f):					
	ecute and tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a		4\.					
60	srificate be executed ing physicien and e as the burial-transit			000 to (01 as a	consequence	11).					
68760	cate physi the	Medical		d	*****						
×	death certificate be executed e attending physicien and nd for use as the burial-transit	_	IF FEMALE:	23c. If yes, outcome o	f pregnancy						
80	atten for u	Physiclan/	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetel death		opic pregnancy er (specify)			23d. Date of deliver Month	very Day Year
o.	the d	ıysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	ino or death	3 🗆 0 11	er (apocity)				
<u> </u>	requires that the death cer een signed by the attendin hould be detached for use		Part It. Other significant conditions of	ontributing to death but	not resulting in	the under	ying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
S	quires n sign	d by							1 □ Ye	s 2 No 3 □ Pro	bably 4 Unknown
Ö	> 0 0	ete							24a. Was ar	24b Were aut	opsy findings available
Vital Records,	The law i	Completed							autopsy	y prior to death?	ompletion of cause of
ta		0	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes 2 ath (Check only one	No 1	2□ No
	₩	To B	examiner? 1 Tes 2 X No	Hospital:	t 2 ☐ ER/Out	patient 3	□ DOA Othe	~	lome 5 Reside	New	we wanted
Ö	g Ph terth neral		27. Manner of Death	28a. Date of Injury (Month, Day	28b. T		28c. Injury Work		28d. Describe ho		Commissing
ō	ath. r: After ne funer	atle	1 Natural 5 Pending 2 Accident investigation		, 647			es 2 No			
Division of		ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjur building, etc.	y - At home, far (Specify)	m, street,	actory, office		28f. Location (Str. City or Town	reet and Number or Rui , State)	al Route Number,
	o the Hospital or ithin 24 hours after to the Funeral Dis ampletely filled in	edlcal C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of hiner: On the basis of e and manner state	examination and	death one Vor investi	urrad at the time gation, in my opi	o, data and plane inion, death occu	in and due to the ca irred at the time, da	use(s) and manner as ite and place, and due	ituled to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	100000000000000000000000000000000000000	11		29c. License	number	29	d. Date signed (Month)	Day, Year)
	- SHO		Jeolle W.	pelau)1	ILMD		D3:	3400			
2	FA		30. Name and a dress of person wh	mpleted cause of dea	ath (Item 23a) /	Tyne Print	1 200			11/1/20	- /
	V		Tredell W. Into	bert III M	D 630	7/	Charles	ST, 166	Umore	9/14/20 2/MD 212	212
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		R3				
	Registr	ar	cen 1	7 2007 \$ 160		600	7 AP A				

To the within 2

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

Assistant Medical Examiner

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD.

31. Date filed (Month, Day, Year,

OCME

29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. September 8, 2007

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Physicia /Medica Examine		1. Decedent's Name (First, N								Douth		lental H	Reg. N	lo.	0,	2968	, 1
	** 1	RUTH S	liddle, La EIFF		ORRIS	5						2. Date of D Month Septer	, D	12,	Year 2007	3. Time of Death 8:57 A.	
	er	4a. Facility Name (If not instit	ution, gi	ve street and nu	mber)				, Town, or	Location	of Death		4	c. County			
Funeral Director		5. Social Security Number 199–07–3131		Sex 1 □ M 2 X F	7. Age (In	n yrs. last bi	rthday) Yrs.	If Unde Months	Pr 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, E Aug. 7	Day, Yea		9. Birthp Coun	ace (State or Fore	ign
Maryland -f show fied at	tor	Usual Residence of Deceden 10a. State 10b. Co Maryland Ba		nore	10	c. City, Tow		cation							1	0d. Inside City Limi	
ath with the 23a or 28a	Funeral Director	10e. Street and Number 2525 Pot Spr		Road						21093				U. S	What Coun		
IIIS a	<u>م</u>	11. Marital Status 1 □ Never Married 2 □ 3 ▼ Widowed 4 □ Divo		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2[XX]No ve	r in U.S.			edent of H ecify Cuba 2 X No	ispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)	10-		ck, White, White, Whi	etc.	
within 72 ho ene. than "natur ne Medical I	Completed	(Specify only h	ghest gr	ducation ade completed) College (1-4or 5+)	16a	(Give I life. D	kind of w	ual Occup ork done d use retired naker	ation during mos d)	st of work	ing	16b.	Kind of B	usiness/Ind	lustry	
fental Hygie ked other i ic event, th	To Be Co	12 years 17. Father's Name (First, Mic Alpheus Llo		Seifre	i				idite!	18. Moth		e (First, Middi Mary	•		ne)		
and 2 shou ealth and M n 27 is mar er traumat		19a. Informant's Name/Related Marsha Cerquit				er) 76	66 C	hick	ory '		. Mu		Hi11	., Ne	w Jer	sy 08062	2
t. Pages 1 tment of He tant: If Iter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremat 4 ☐ Donation 5 ☐ Oth	er (Speci	ify)	State	cemete Green	ery, crem Mou	natory or nt (other plac Crema	tory	9-1	.3-07	Ba	ıltim		Maryland	
Depar Impor any ir		21. Signature of Funeral Ser	11	ena		- death Do						l Funer Baltimo		Home, Mary	Inc. land	21212 Approximate	
Physician /Medical		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only	_a	000	rest	Tue	- 1	lea	- 1	1	allor				Interval Between Onset and Death	
icate be executed physician and sthe burial-transit	edical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):								years							
E 00 66	Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t		birth 2 🗀 nant at time	Fetal deat		Ectopic	pregnancy specify)	/					te of delive	ry Day Year	
w requires that it been signed by should be detar	≥	Part II. Other significant cor	ditions	contributing to d	eath but no	ot resulting i	in the un	iderlying	cause give	en in Part	l.					e cause of death?	
: The law requirate has been page 2 should	Completed												topsy rformed?		prior to cor death?	osy findings availal npletion of cause c 2 2 No	ble of
hysici this cer al direct	n: To Be	Was case referred to me examiner?		28a. Date	1		utpatient Time of Injury	t 3 🗆 🗆	OOA Other	er: 4 □ N vat		h (Check only ome 5 Re 28d. Describe	sidence		ner (Specif	ISTED ILV	IW
l or Attendir after death. Director: Al I in by the fu	Certification:	2 ☐ Accident inv	estigatio uld not t termined	pe 28e. Place		At home, fa		M eet, facto		Yes 2□	No	28f. Location City or T			per or Rura	l Route Number,	
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C			hysician: To the miner: On the b and mar		amination a											
To t Com	Σ	29b. Signature and title of ce	st	nce h	<u>On</u>	ght,	M		9c. Licens	e number)4(0	29d. E	Date signe	d (Month	Day, Year) 10 12 14 70	67
State Registra		30. Name and address of pe ERNESTINE W 31. Date filed (Month, Day, N	RIGH	T, M.D.	230 Registrar's	O DUL	ANES	VA.		ROAD	TII	MONIUM,	, MD	2109	93		

Baltimore, Maryland 21215-0036

8:57 A.M.

SEPTEMBER 12, 2007

RUTH NORRIS SEPTEMBER 12, 20
Division or Vital Records, P.O. Box 68760,

		Please Type or Print in Black Indelible Ink. Ensure A		-	
		1- State of Maryland / Department of Health and No. Certificate of Death		giene Reg. No. 2007	29688
Physi /Med		1. Decedent's Name (First, Middle, Last) Thomas Osman Jr.	2. Date of De- Month Septemb	er 13 2007	3. Time of Death 7:07 PM
Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Hospice Timonium		4c. County of Deat	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da May 26,	y, Year) Co.	nplace (State or Foreign untry) INOWN
ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
th the Ma or 28a-f s e notifiec	Funeral Director	Maryland Baltimore Baldwin 10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	
death wi	eral [14238 Baldwin Mill Rd. 21013 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecity Yes or No	United Sta	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	à	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto 1 ☒ Yes 2 ☐ No If Yes, Specify Cuban, Mexican, Puerto 1 ☒ Yes 2 ☒ No Specify:	Rican, etc.)	Cassifu	e, etc. nite
215-C	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	ring	16b. Kind of Business/	ndustry
1 212 lied with tygiene her tha	Som	12 maritime engineer 17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Name	o /Eiret Middle	engineeri	ng
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic eveni	To Be	Thomas Osman Sr. unkno	wn		
and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Type. Print) John Wisor/Executor 19b. Mailing Address (Street and Number or Rut 3307 Saddlehorse Ct.	al Route Number Glenwo		
ages 1 and of the filter 2 or other		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date	20c. Location - City or	
Baltimore, permit. Pages 1 a Department of Hea Important: if item any injury or othe	93	4 Donation 5 Other (Specify) Green Mount Crematory Sep. 21. Signature of Funeral Service Licensee Mitchell Wiede 6500 York Rd.			
- 005 e		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	Balti or respiratory a	more, MD 2	1212 Approximate Interval Between
Physicia: /Medica		Immediate Cause (Final disease or condition a. LUNG CANCER			Onset and Death
Examine	ŕ	Due to (or as a consequence of): Sequentially list conditions b.			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.			
oertificate be executed certificate be executed ding physician and use as the burial-transit		resulting in death) Last Due to (or as a consequence of):			
EOX 68/6U, eath certificate be exattending physician for use as the burial	Medic	IF FEMALE:			
atter for u	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of deli Month	very Day Year
VITAL RECORDS, P.O. siclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to Yes 2 No 3 Pr	
The law r cate has be page 2 sh	Completed		24a. Was autor perfo 1∐ Yes	osy prior to o ormed? death?	topsy findings available completion of cause of 2 ☐ No
Or VICAL Physician: 1 rithis certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 Norsing Ho		ene) dence 6 X Other (Spec	city) HOSPICE
— D • •	tion: T	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 4 Work? 4 Work?		how injury occurred	· HODI TOD
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (3 City or Tox	Street and Number or Ru vn, State)	ıral Route Number,
e Hospita 124 hours e Funeral	edical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the vithing to the comp	Me	29b. Signature and title of certifier 29c. License number 29c. License number		29d. Date signed (<i>Monta</i>	
101		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
-	tate	DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, 31. Date filed (Month, Day, Year) SEP 1 7 200 32. Registrar's Signature	MD 210	73	
Regis		SELT 1 COOL SECTION SEL SECTION			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 29689 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:07 A M Kerry 9 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Joseph Richy Hospice Baltimore NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min. 219-70-3848 Director 56 2-29-1956 Mich. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Md. Baltimore Woodlawn 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zíp Code 10g. Citizen of What Country? "natural", or Items 23a or 3 3315 Milford Mill Rd. 21244 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. snt: If Item 27 is marked other than "natural", or Items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No <u>}</u> Specify: Black Completed the M dical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Welder Various Item 27 is marked other other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John s. Pass Virginia Branford ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Anderson 3315 Milford Mill Rd., Woodlawn, Md. Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of HIMPortant: If Ite any injury or of XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet: 9-18-07 4 Donation 5 ☐ Other (Specify) Owings Mills, Md. 22. Name and Address of Facility ignatur of Funeral Service Lips March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part 1 Enter the disease, or complications that caused shook, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, edi e Cause (Final as or condition Due to (or as a consequence of): Physician g in death) /Medical xtocalolar **Examiner** Caronana Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Havrey burial-trar Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b page 2 s autopsy performed 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Diother (Specify) Hobbil 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: funeral After ours after death.
neral Director; A'
filled in by the fu within 24 hours a

To the Funeral C

completely filled

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

HOD 64

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day,

Charles Thadeus		- For State	h and Mental	Hygiene 2007 2969					
Physicia Medical Examir	ın/	1. Decedent's Name (First, Mid-					2. Date of Death Month September	h Day Year	3. Time of Death 1910 hrs
Medical Examin		4a. Facility Name (if not institut		rye, Ji	4b. City, T	own, or Location of De		4c. County of De	eath
Funeral		268 Harry S. Trumar 5. Social Security Number	6. Sex 7. Age	(In yrs. last birthd	Largo ay) If Unde	r 1 Year If Under 24	4Hrs. 8. Date of Birt	h(MM/DD/YYYY) g.	Birthplace (State or
Director		084 32 6238	1 M 2 F	67	Yrs. Months	B Days Hours	Min. July 10	,1940	reign DC CountryWashington
CA SERVICE AND ARTHUR AND ARTHUR AND ARTHUR AREA AREA AREA AREA AREA AREA AREA AR	40.00	Usual Residence of Decedent 10a. State 10b. County	, <u> </u>	10c. City, Town or	Location				10d. Inside City Limits
yland •-f show once.	후	Maryland Prin 10e. Street and Number	ce Georges	Largo	10f. Zip	Code	110	Og. Citizen of What C	1 Yes 2 XXNo
Baltimore, MD 21215-0036 permit Pages I and 2 shouldbe filed within 72 hours after death with the Maryland Department of Health and Meinal Hygiene. Important: If item 27 is may ked other than "natural", or items 33a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director		S. Truman Dr	ive	101. 219	20774		United St	
ath with tems 23 st be no	Funeral	11. Marital Status 1 Never Married 2	12. Was Decedent E Armed Forces?			nt of Hispanic Origin? y Cuban, Mexican, Pu		14. Race - Ar White, et	merican Indian, Black, c.
after de	by Fu		ivorced If Yes, Give Year	X No		XX No specify:	,	Specify:	ack
2 hours		 Decedent's Education (Sp Elementary/Secondary (0-12 		+) du	ring most of wor	Occupation (Give kind king life. DO NOT use	e retired) . '	16b. Kind of Busine	ways to make the beautiful to
0036 within 7 gene. ner than	Completed	12			Excess	Warehouse	Manager Name (First, Middle, M	Dept. o	f Agr.
215-(be filed ntal Hyg rked oth	Be C	17. Father's Name (First, Middle Charles T. Py				Rathi		walden Sumanie)	
ID 21 should and Me 77 is ma		19a. Informant's Name/Relation Michelle Gatli			-	(Street and Number ford Lane,	· · ·		
re, M s I and 2 f Health If item 2 er traus	on 4.0	20a. Method of Disposition	on 3 Removal from Sta	20b. Place of		ne of cemetery.	Date	20c. Location - Cit	
ti Pages trient of rrant: I		4 Donation 5 Other	Specify:	Lee Cr		Sept 11,		Clinton,	MD c 6633 Old
Bal permi Depar Impo injur		21. Signature of Funeral Sorvice	- MOIS	391	Alexan	sdria Ferr	y Road, Cl	inton, MD	20735
Physician Medical		21a Part I. Enter the disease, failure. List only one caus	se on each line.		enter the mode	of dying, such as card	liac or respiratory are	est, shock, or heart	Approximate Interval Between Onset and Death
`xaminer		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a conse	equence of):				7	
	je	Sequentially list conditions, if any, leading to immediate	b. Hypertensive C. Due to (or as a conse		Disease	5 , 3			Z.
	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	C.	equence of):					
e executed ician and urial - transit	dical E	UNPENDED	d						
be be	/Med	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcom	ne of pregnancy		2 Fetenie n		23d. Date of del	livery Day Year
OX 68760, eath certificate b attending physic	sician/Me	past 12 months?	4 Pregnant at	time of death 5	Fetal death Other (Spe	3 Ectopic p	regnancy	Mouth	Day Poar
മെ ഉപ	Phy	Part II. Other significant cond	a Olikilowii	n but not resulting	in the underlying	cause given in Part	I. 23e. Did to	obacco use contribut	te to the cause of death?
ords, P.O. I w requires that the as been signed by t	ed by						1 Ye	s 2 No 3	Probably 4 Unknown re autopsy findings available
Cord: law req has bee	Completed	, -					autor	psy prio prmed? dea	r to completion of cause of th?
al Re nn: The rrificate tor, pag	Be Cor	25. Was case referred to medi	cal			26.Place of Death (C		2 No 1	Yes 2 No
f Vita Physicia er this ce	2	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie			OOA Other 2 N	Nursing Home 5	Residence 6 🗸 (Other: Scene
ON O rending sath. or: Afte	tion:	1 V Natural 5 Pe	(Month, Day,Y ending vestigation			1 Yes 2 N			
Division of Vital Records, To the Hospital or Attending Physician: The law requirivithin 24 hours after death. To the Funeral Director: After this certificate has been sicompletely filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Co	build not be etermined (Specify)	ijury - At home, fan	m, street, factor	y, office building, etc.	28f. Location (or Town,		or Rural Route Number, City
Hospit: 24 hour Funera		29a. Certifier 1 Certifying	Physician: To the best of m	y knowledge, deat	h occurred at the	e time, date and place	e, and due to the cau	se(s) and manner as	stated.
To the Hos within 24 h	Medical	29b. Signature and title of cert	xaminer:On the basis of examiner and manner stated.	mination and/or in		c. License number	irred at the time, date		(Month, Day, Year)
-	_	(a, of	HOLLE	2v		O.C.M.E.		September 7	, 2007
7		30. Name and address of pers	on who completed cause of d		Penn Street.	Baltimore, MD 2	21201	•	
Si	tate			r's Signature	Constant D				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:15 P M September 6, 2007 Renee Pope Judy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🛛 F Sep.8, CA 497-68-1292 Director 46 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Items 23a or 2 iner must be no USA 20877 374 Summit Avenue, Apt 204 **Examiner must** Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo within 72 hours after 1 TNever Married 2 Married 1 ☐ Yes 2 X No White Baltimore, Maryland 21215-0036 'natural", or Specify. þ 3 □ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Freelance Artist Self Employed 12 4 permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygic Important: If Item 27 is marked other I any Injury or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peggy Jean Osborn Clyde Hershel Pope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Jean Starbuck/Mother 1004 W. LaHarpe, Kirksville, Missouri 63501 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maple Hills 20c. Location - City or Town, State 20a. Method of Disposition 1 EBurial 2 ☐ Cremation 3 ☐ Removal from State 9 - 10 - 07Kirksville, Missouri 4 □ Donation 5 □ Other (Specify) Cemetery Travis-Noe Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 63501 1008 W. Potter Avenue, Kirksville, MO Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** chal Cequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, physician s the burial Physician/Medical as attending properties for use as If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a Date of Injury 27. Manner of Death After (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical 29a, Certifier c. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who

d cause of death (Item 23a) (Type, Print)

29d. Date, signed (Month, Day, Year)

LAKOMA FAR

State of Maryland / Department of Health and Mental Hygiene 17

			For State Registrar	State of Ma	aryland	/ Depa <i>Cer</i>	rtment of I	Health <i>Death</i>	and M	lental	Hygier Reg. 1		17	296	92
ľ	Physicia	20	1. Decedent's Name (First, Middle,	,			D - l		_	2. Date of	of Death		/ear	3. Time of	Death
*	/Medic		Bertha		Ĺ •			oinso		09	10	0 07		6:20	a.M
	Examin	er	4a. Facility Name (If not institution, state 1314 North Medium)		ve		4b. City, Town,	or Location altim			4	4c. County of	Death		
27	Funeral			. Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date		, ,	9. Birthplac	ce (State o	r Foreign
и	Director		212-44-1041	1□M 2X1F	59	Yrs.	Months Days	Hours	Min.	05	h, Day, Yea 01	48	Country		D
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation						10d	. Inside Ci	ty Limite
	Maryla f sho led at	ō	MD NA				ltimore	.					100	1 X Yes	
	r 28a- notif	Director	10e. Street and Number				10f. Zip Code				10g. (Citizen of Wh	at Country	?	
	th with		1314 North Mo	ntford Av	e		2	21213	}			U.S	. A .		
	be filed within 72 hours after death with the Maryland ntal Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of f Yes, specify Cul	Hispanic Or oan, Mexica	rigin? (Spe	ecify Yes	or No-		American White, etc		
36	s afte	Y.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	d 1 □ Yes 2 🔀 If Yes, Give Year or Dates:	No		□Yes 2X No					Specify:	Bla		
21215-0036	2 hour	Completed by	15. Decedent's	Education	T		lent's Usual Occu				16b.	Kind of Busi			
215	hin 72 e. an "na Media	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or !	5+)	(Give life. L	kind of work done OO NOT use retire	during mo: ed)	st of worki	ing				-	
21	ed wit	S	9th grade	na			Chei	_				Job C			
Maryland	d d o	Be	17. Father's Name (First, Middle, La Fred Singleto	,				1		, ,	iddle, Maid ards	len Surname))		
7	should be f and Mental b s marked of umatic ever	ပ္	19a. Informant's Name/Relationship			10h Mailin	g Address (Stree					ar Town S	tota Zia C	ada)	
Ma	# 7 # d		Kesha Robinso				North								2121
re,	s 1 and 2 of Health item 27 I		20a. Method of Disposition			e of Dispo	sition (Name of natory or other pla	ace)		Date	20c.	Location - C	ity or Towr	n, State	
m	Page nent c int: If iny or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				orial 1		9/1	5/20	07 R	andal	lsto	wn,	Md
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Li	censee	Q	Ma 43	Name and Addr rch F/1 00 Waba	ess of Facil H Wes	ity St Ave,	Bal	timo	re, M	.d 2	1215	 5
5			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caused nly one cause on each li	d the death. ne.								A II	pproximat iterval Bet	ween
7	Physician		Immediate Cause (Final disease or condition resulting in death)	_a END	STAG	ERE	NAL I	ISEA	Æ					onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or as		,		./							
6	4555	ē	Sequentially list conditions, if any, leading to immediate	b. SEVE			RTENSIO	<i>N</i>					_		
W	cuted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
8760,	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequer	nce of):									
876	ate be	dical		d											
9 x	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outcome	of pregnanc	ev						004 0-4	-6 -1 - 1		30
Box	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregnand Other (specify)	су				23d. Date Mont	,		Year
0	at the de by the	nysi	1 ☐ Yes 2 █ / No 9 ☐ Unknown	9□ Unknown			, (0, 00)								
S, P.	res thai igned t be det	by P	Part II. Other significant condition	s contributing to death b	ut not resultin	ng in the ur	nderlying cause g	iven in Part	l.	23e.	Did tobacc	o use contrib	oute to the	cause of c	death?
ord	w require been sign	ted									1 Tes	2 ≝ No 3	B ☐ Probab	oly 4 □l	Unknown
Records,	e law r has be je 2 sh	Completed								24a.	Was an autopsy	pri	ere autops	y findings pletion of c	available ause of
al H		Son								10	performed Yes 2	No 1 [ath? Yes 2	□No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				her:	e of Deatl						
0		2	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry 2	R/Outpatien 8b. Time of	1 30 DOX	4 LJ N	1			6 Other			
ion	Attending Ph r death. ector: After th by the funeral	tio	1 Matural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da tion	y Year)	Injury		orƙ?]Yes 2.[. ,			
Division	l or Attencatter death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of inj	ury - At home	e, farm, str	eet, factory, office)		28f. Local	tion (Street or Town, St	and Number	r or Rural F	Route Nun	nber,
Ö	ital or rs after ral Di	Se		,											
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical	29a. Certifier 1	Physician: To the best xaminer: On the basis of and manner st	of examination ated.	n and/or in	vestigation, in my	opinion, de	ath occur	red at the	time, date	and place, ar	nd due to t	he cause(,
	To the within 2 To the complet	Ž	29b. Signature and title of certifier				29c. Licer	se number			29d.	Date signed	(Month, Da	ay, Year)	~~
	la.		Caeyarsfood	IAI			210	0617			50	ptembe	u /=	1, 200	01
	3		30. Name and address of person w	ho completed cause of c	leath (Item 2:	3a) (Type,	29c. Licer D/6	RE D	R. 12	BALT	MOR	EM	0. 21-	236	
1	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 7	2007 32 Aegisti	rar's Signatur	Sport	alis.								

7-07169		Please Type or Print in Black Indelibl		_	ble.	
ugene George		1- For State Certificate		Reg.	NO.	7 2969
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Eugene G. Rossmark, Jr.		2. Date of Death Month Di September 1	ay Year 15, 2007	3. Time of Death 0115 hrs
		Facility Name (if not institution, give street and number) 1214 South Marlyn Avenue	4b. City, Town, or Location of Death Essex	1	4c. County of Death Baltimore Cou	nty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs Months Days Hours Mir		MM/DD/YYYY) 9. Birtl Foreigi	1
Director		217-21-8919 1\overline{X} M 2 F 28	Yrs.	04-22-1	979 Cou	intry)Maryland
ow any		10a. State 10b. County 10c. City, Town or L Maryland Harford Bel Ai:				10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show	Director	Maryland Harford Bel Ai:	10f. Zip Code		Citizen of What Coun	
with the Maryland ns 23a or 28a-f sho pe notified at once.		785 S. Atwood Rd 11. Marital Status 12. Was Decedent Ever in U.S. 13	21014 . Was Decedent of Hispanic Origin? (S		U.S.A.	can Indian, Black,
5-0036 ed within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f sho	Funeral	1 Never Married 2 Married 1.2 Was Decedent Even in C.S. 13 Mills Never Married 2 Married Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		White, etc.	7.5
nours afi natural	ed by	Lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use re		6bKind of Business/Ir	
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	tems Mechanic		Harford Co	unty
	Be Cor	17. Father's Name (First, Middle, Last) Eugene G. Rossmark, Sr.	18.Mother's Nam Dawn K	e (First, Middle, Mai	iden Surname)	
_ 20 0 2	To B	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or	Rural Route Numbe		Zip Code)
re, MD 1 and 2 sho 1 Health and fitem 27 is	a-4 6	20a. Method of Disposition 20b. Place of D	sposition (Name of cemetery,		20c. Location - City or	Town, State
Baltimore, permit, Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Bayview	7	-20-2007	Baltimore,	Maryland
Baltimo permit. Page Department of Important:			22. Name and Address of Facility Sc 610 W. MacPhail Rd			e of Bel Air
Physician /Medical		23a, Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot wounds (two) of head one of the condition resulting in death) Due to (or as a consequence of):	مارد ودد ا	* * .//-		Death
	-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	i i i i i i i i i i i i i i i i i i i	<u> </u>		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		** 95		
xecuted n and l - transit	ā	d. UNPENDED AMENDED				
760, ficate be exe g physician a	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
x 68 n certifi ending use as	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr Other (Specify)	ancy	Month D	Day Year
P.O. B es that the d igned by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to	- Investigation of the last of
cords, P.O. Box iaw requires that the death nas been signed by the att 2 should be detached for	ted b	ļ , -		1 Yes	2 ✓ No 3 Prob	ably 4 Unknown topsy findings available
Recor The law ricate has b	Completed			autopsy performe 1 ✓ Yes 2	ed? death?	completion of cause of second 2 No
Vital Rec tysician: The this certificate director, page	BeC	25. Was case referred to medical examiner? Hospital: 4 Innation 2 FR/Output	26.Place of Death (Check			
of Viring Physical After this	ို	1 Yes 2 No Imparent 2 Errodust	e of Injury 28c. Injury at Work?	ing Home 5 Re 28d. Describe how	esidence 6 🗸 Other winjury occurred	: Scene
Division of Vital Records, spital or Attending Physician: The law requirement after death. Increase of the control of the con	Certification:	1 Natural 5 Pending Sep 15, 2007 0000 hi	Yes 2 No	Subject shot		
Divis ital or A irs after or al Direc	ertific	3 Suicide 6 Could not be determined Specify Townhouse / Row		or Town, Stat		ral Route Number, City ore, Md
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Medical Examiner: On the basis of examination and/or inve				
To Your To Control	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moi	
10		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	;	September 15, 2	
10		Ana Rubio MD. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 2120)1		
Si	ate	31. Date filed (Month, Day, Year) 32. Regis s Signature	.0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CA 14 2000 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rambling Daks Way Aportment H 154 1 more Cutonsville 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Min. 1 □ M 2 □ F 219-40-7699 9/20 MD 1194 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X ☐ No MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Ramblin Oaks Way Apt H U.S.A. 21228 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert W. Livesay Minnie Anderson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Riley / Husband Ramblin Oaks Way Apt H Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XI Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park: 09/17/2007 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Srv 21. Signature of Funeral Service Licensee 1 2nd Avenue SW Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiloper phlymmia month Due to (or as a consequence of) ulmmay disence Stage IV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by tension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Whom autopsy performed 1 Yes 2 → No 25. Was case referred to medical examiner? ath (Check only one)

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural", or

the Medical

72 hours after

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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and burial-tra attending physician the as use Ь ed by the a signed by det has page 2 certificate this

After

death.

after death

certificate be executed

Division or Vital Records, P.O. Box 68760

9 Completed Be 2 27. Manner of Death

2 | 1100

29b. Signature and title of certifier

6 ☐ Could not be

1 ☐ Yes

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Physician/Medical filled in by the

Certification:

within 24 hours a To the Funeral I the

Hospital

State Registrar

Medical

<i>ì</i> (kidney	de sence	Stugi	e III
				26. Place of De
	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatient	3 DOA	Other: 4 Nursing I

28b. Time of 5 Pending investigation

28a. Date of Injury (Month, Day Year) М

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month. Dav. Year)

Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed

3212

700 Geipe Road

Catonsville, MD 21228

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print) MD

bernita 10 32. Registrar's Signature 31. Date filed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 HYMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Count Clinton Maryland Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jul. 20, 5. Social Security Number **Funeral** Months 1 M 2 X Days Hours Director 89 NC 239-24-1403 1918 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 TYes 2 TNO Director MD Prince George Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20716 USA 5117 Whitfield Chapel Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: Black þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnnie Clara Barnhill ပ Claudie Hyman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; if item 27 is any injury or other trat once. Joyce Rascoe-Tillman /Daughter 5117 Whitfield Chapel Rd., Lanham, MD Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Indian Wood Church 1 Burial , 2 ☐ Cremation 3 ☐ Removal from State 9-8-2007 4 □ Donation 5 □ Other (Specify) Windsor, NC 21. Signatury of Funeral Service Ligensee 22. Name and Address of Facility Manson Mortuary, Inc. 27892 415 Washington St., Williamston, NC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EPSI /Medical Due to (or as a consequence of) ~15 HRS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unions of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Par

been signed by the s funeral s after dea. ral Director: Aftr

þ Completed 25. Be Certification: To 27. 298 Medical

29b. Signature and title of certifier

Date filed (Month, Day, Year)

FELICIA

nd address of person y

Nicetalson brown

	No	Hospital: Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 C C 28b. Time of Injury M	Other:	ath (Check only one) Home 5 ☐ Residence 28d. Describe how in	6 □Other (Spec	2 □ No
Was case referexaminer?	red to medical	119.1		OA Other: 4 Nursing	eath (Check only one)		
Hypu Was case refer		`		26. Place of De		No 1∐Yes.	2 □ No
	Jensie				1 Yes 2 X	No∣ 1∐Yes.	2 □ No
Di	ibetes				24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
t II. Other signif		ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to 2 ⊠ No 3 ☐ Pro	the cause of death?
EMALE: b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	I death 3 ☐ Ectopic			23d. Date of delive	very Day Year
	ast	Due to (or as a conseq	uence of):				
ise. Enter Unde use (Disease of t initiated events ulting in death) I	injury	0					

29c. License number

SURRATTS RA

29d. Date signed (Month, Day, Year)

Clinton MD 20735

DHMH 17 Rev 1/2001

State Registrar

within 24 hours a

7503

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MO

State of Maryland / Department of Health and Mental Hygien 0 7

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	/Medi Examir		4a Facility Name (If not institution, give		<u>ubon</u>		4b. City, Town, or I			of Death	10.15	
Y	LAUTITI	o	Prince George's M	ledical Center	•		Cheverly	.7	Prin	ce Ge	eorge's	
-	Funeral		5. Social Security Number 6. Sec			If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Bi (Month, D			plece (State or Fo	oreign
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	ylan how		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	10d. Inside City L	
	Ma Filed	to	MD Prince Ge	orge's I	anham						1 ∑ Yes 2	□No
	4 28 B	Director	10e. Street and Number			10f. Zip Code	9		10g. Citizen of	What Cour	ntry?	
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la	should be ind Mantal marked o	0	Owen Munn				Leaha	Counci:	1			
Maryland 21215-0020	d 2 should th and Mar 7 is marke traumatic		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Stre	et and Number or Ru	ırel Route Numl	ber, City or Town	, State, Zir	Code)	
	C = 0 -		Carolyn Robinson/				Avenue, La	anham, l	MD 2070	6		
Sre	of Healt item 2		20a. Method of Disposition		Place of Disposemetery, cren	sition <i>(Name of</i> natory or other p	olace)	Date	20c. Location	- City or To	own, State	
Ĕ	Pege int: if		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	D-4 -	rst New	Light	Church Cer	m. 9/15	/07 Whi	.te 0	ak, NC	
Baltimore,	permit. Peges 1 Department of H Important: If Itel any Injury or ott		21. Signature of Funeral Service License	99	22	. Name and Add	dress of Facility	Colvin :	Funeral	Home	, Inc.	
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	Dhusisian		shick, or heart failure. List only or	ne cause on each line.			, , ,	,		1	Interval Betwee Onset and Deat	en ath
- 4	Physician /Medical	~	Immediate Cause (Final			. 14	-	n.		į	**	
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Division	or A after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specif		ot, lactory, onle			wn, State)			
_	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge death	occurred at the	time, date and place	and due to the	cause(s) and m	anner as s	stated.	
	24 h	edicai	(Check only 2 Medical Examir one)	ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in m	y opinion, death occu	rred at the time	, date and place,	and due to	the cause(s)	
	o the	M	29b. Signature and title of certifier	-		29c. Lice	ense number	-	29d. Date signe	d (Month,	Day, Year)	
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	1		20 Name and district	- new	120 /T	DO1	852		Septe	nper	10, 2007	/
	4		30. Name and address of person who co				Cheverly,	MD 207	25			
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			for State Registrar			Marylar	hď / Depa Cei	artme rtifica	nt of H	eáith áhd Death		Heg. N	200	7 2	2969	
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	/Medic	cal	William 4a. Facility Name (If I	not institution, give		tely	Sr.	4h Cit	. Tourn or	Location of Deal	Septe		c 8, 20	007	330 A	IVI
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	r 28a-	Director	10e. Street and Num		01		HOWELL	10f. 2	ip Code			10g. 0	Citizen of Wha	t Countr	y?	_
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	Sta	ite	31. Date filed (Mont	SEP'I"7 2	007 32.	istrar's Sign.	ature	A A								

State of Maryland / Department of Health and Mental Hygiens 2007 29698

Certificate of Death Reg. NO. 007

			Registrar	Cer	unicate of L	Jeani		Reg. No.	• • •	
	Physicia	Ter .	Decedent's Name (First, Middle, Last) Jatinder Samra				2. Date of De Month Septemb	Day	Year 2007	3. Time of Death 11:10A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		рересии		ounty of Dear	
	LAGIIIII	ĢI	6541 Ballymore Lane		Clarks	ville		1	Howard	
2	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last)	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State or Foreign
	Director		438-55-6515	Yrs.	Months Days	Hours Min.	(Month, Da			ndia
-		ł	Usual Residence of Decedent			l	100 0,	1,00		
	ylan now at		10a. State 10b. County 10c. City, To	own or Loc	ation					10d. Inside City Limits
	a-fs	ફ	Maryland Howard	Cla ₁	rksville					1 □Yes 2 No
	h the	Director	10e. Street and Number		10f. Zip Code			10g. Citize	n of What Co	ountry?
	th with	a	6541 Ballymore Lane		210	29		Uni	ted St	ates
	dea ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No	- 14	. Race - Ame Black, Whit	
٥	after or its		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give		☐ Yes 2 No	Specify:	,,			
2-003p	ours iral", Exa	d by	3X Widowed 4 ☐ Divorced Year or Dates:						AS	ian- Indian
5	72 h 'natu dica	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced (Give I	ent's Usual Occupa kind of work done o O NOT use retired	ation Juring most of work	ing	16b. Kind	of Business	/Industry
7	/ithin ne. han '	ם	Elementary/Secondary (0-12) College (1-4or 5+)					0	n Busi	2000
V	led w lygie her ti	ပ္ပ	47 Estanda Mana (First Middle (ant)	Sa.	les Perso	18. Mother's Name	o /Eirot Middle			ness
yland	be fi	Be	17. Father's Name (First, Middle, Last)						irrarne)	
Š	ould Mer narke	ို	Devinder Samra		1	Rajwa		Gill	- 0	
	2 sh and rang				g Address (Street a			-		· /
1	and lealth m 27 her t				Ballymore sition <i>(Name of</i>		larksvi _{Date}		Maryla tion - City or	nd 21029
5	ges 1 t of H If ite or ot		1 Burial 2 Cremation 3 Removal from State	etery, crem	natory or other plac	e)			•	
	men tant: jury				Cremator		/2007			aryland
baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show important: If them 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	D0	. Name and Addres onaldson	ss of Facility Funeral	Home &	Crema	tory,	P.A.
_	0 5 8 9		Marita K Homos	14	411 Annap	olis Roa	d Oden	ton, l	Maryla	nd 21113
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
E	Physician		Immediate Cause (Final disease or conditiona Ischemic Card	iomy	opathy					1 year
	/Medical		resulting in death) Due to (or as a consequence							
	Examiner		Sequentially list conditions b. Ischemic hear		sease					2 year
	p #	ine	Sequentially list conditions, if any, heading to financiate cause. Enter Underlying	se of):					1	
	ecute ind trans	am	that initiated events c. Ischemic Hepa		S					1 month
Š	e exe	<u> </u>	resulting in death) Last Due to (or as a consequence	ce or):						
00/00	ate b hysic the b	n/Medical Examiner	d							
Ŏ	ertific ing p	Med	IF FEMALE:							
X O	ath co		23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 🗌				23	d. Date of de Month	livery Day Year
5	e deg	Sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 5	Other (specify)					24, 104
Ţ.	d by tetach	Physicia	Part II. Other significant conditions contributing to death but not resulting	a in the un	derlying course circ	an in Part I	230 Did 6	ohacco uco	contribute t	o the cause of death?
ń	res the	by	Part II. Other significant conditions contributing to death but not resulting	g in the un	denying cause give	enin Fanti.		Yes 2 🗖		
ecords,	requi	ted						ies ZIX	NO 3[]F	robably 4 □Unknown
ວັ	law as be	ble					24a. Was auto	psy i	24b. Were a prior to	utopsy findings available completion of cause of
ב	The ate has page	Completed					perfo 1∐ Yes	rmed?	death? 1 ☐ Yes	
N II G	stan: ertific ctor,	Be (25. Was case referred to medical examiner?			26. Place of Deat				
_	nysiq nis ce direc	70		Outpatien	t 3□ DOA Othe	er: 4 Nursing Ho	ome 5 4⊡ Resi	dence 6[□Other <i>(Spe</i>	ecify)
0	Attending Physician: r death. ector: After this certific. by the funeral director,		27. Manner of Death 1	b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe			
SION	ath. or: Ai	atic	2 Accident investigation		M 1□	Yes 2 □ No				
<u> </u>	er de recte	iệ l	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (City or To	Street and i	Number or R	ural Route Number,
5	tal o	Certification:								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Check only Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination							
	the I	Medical	one) and manner stated.							``
	To Too	≥	29b. Signature and title of certifier (H) enaling physics	icia	29c. License	e number		29d. Date	signed (Mon	th, Day, Year)
			all Se		D449	973		Sep	tember	13, 2007
	2		30. Name and address of person who completed cause of death (Item 23a					71		
	σ		Gurmeet Sawhney, MD 325 Hospital	Dr.	Glen Bur	nie, MD	21061			
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		L+ 12 .					
	Registr	ar	SEP 1 7 2007	X A	may !					

	Physicia /Medic		1. Decedent's Name (First, Middle, L	HARDY STO	UT			2. Date of De Month	Day	Year 3 07	3. Time of Death 0545 M
	Examin	er	4a. Facility Name (If not institution, g. St. Marys H			Leonar	r Location of Death	1		County of Death	ys County
	Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Bir	d-la	0 Dist.	place (State or Foreign
1	Director		410 26 6754	XX ^{M 2□ F} 83	Yrs.	World's Days	TIOUIS WIII.	April	25,1	1924 Te	enn
3	land DW		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sho fied a	tor	Maryland Prince	George's Ter	mple H	ills					1 ∐Yes XXNo
	n with the	al Director	10e. Street and Number 3800 Hemlock	Place		10f. Zip Code 20748				en of What Cou ed Stat	
-	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.		dispanic Origin? (S an, Mexican, Puert	pecify Yes or No to Rican, etc.)). 14	4. Race - Americ Black, White,	
000	illed within 1/2 hours after death with fre Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced		I	1□Yes 2□No	Specify:			SpecifyWhit	
	'natu 'natu	letec	15. Decedent's l (Specify only highest g	Education trade completed)	16a. Dece	dent's Usual Occup kind of work done	pation during most of wor d)	rking	16b. Kind	d of Business/In	ndustry
7	within iene. than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Super		<i>u</i>)		Uti	lity Co	mpany
2	other other vent, 1	BeC	17. Father's Name (First, Middle, Las	st)			18. Mother's Nan			Surname)	
3	≥ should be filed with and Mental Hygiene. Is marked other that raumatic event, the Mental the Men	P P	Hardy Stout				Beu1	ah Verb	le ———		
Mal	permit. Pages 1 and 2 should be lined within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship David Stout (SO)	N)	7007	Sundays	Lane, Fr	edrick,	MD 2	1702	
ב ב	ges 1 t of Hi if Iter or oth		20a. Method of Disposition VDBurial 2 □ Cremation 3				ce)Sept 21			ation - City or T	•
	rt. Par rtmen rtant: njury		4 □Donation 5 □ Other (Spec	cify) Mar	-		Cemetery ess of FacilityLee			tenham,	
ם	permi Depa Impo any ir		21. Signature of Funeral Service Lic	Delal sai	_ 4 -		Ferry Ro			•	735
8			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the deat		er the mode of dyi	ng, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between
P	hysician	81 1	Immediate Cause (Final disease or condition	P neumon	à.						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		1 - 1 1	eral Jch	/			
	-xuiiiiioi			501/10- 2	MUMATIN	an. Lali	1 0//-X .1 (-1)				
		100	Sequentially list conditions,	b. Due to (or/as a conseq	uence of):	This raise	crac oci	010)1).			
7	uted d ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injusted events	b. Due to (or as a conseq	juence of):	ynic rain	Ofac OCI	010)11			
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,0070	ate be executed hysician and the burial-transit	dical Examiner	that initiated events	c. Sentic sho	CIC.	y nic round		070313			
, 00 / 00,	certificate be executed ding physician and se as the burial-transit	/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Son Fic Sho Due to (or as a conseq d.	y C/C.	ynic rain		070515	20	3d Date of deliv	uen.
DOX 007 00,	death certilicate be executed a attending physician and for use as the burial-transit.	cian/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. Syntic Sho Due to (or as a conseq d. 23c. If yes, outcome pf pregni 1 Live birth 2 Pregnant at time of d	quence of):			970 9 1 9 1	20	3d. Date of deliv	rery Day Year
.O. DOA OO! OU,	it the death certificate be executed by the attending physician and tached for use as the burial-transit.	cian/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	c. Superior	quence of):	⊒Ectopic pregnanc			23		,
S, F.O. DUA 00/ 00,	es that the death certilicate be executed gned by the attending physician and be detached for use as the burial-transit	Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	c. Surfic shoot Due to (or as a consequence of d. 23c. If yes, outcome pf pregnance of depretation of depretat	ancy al death 3 Edeath 5 E	⊒Ectopic pregnanc	у	23e. Did	tobacco us	Month se contribute to	Day Year
Olds, F.O. BOA 667 60,	requires that the death certhicate be executed the signed by the attending physician and hould be detached for use as the burial-transit.	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	c. Surfic Sho Due to (or as a conseq d. 23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ancy al death 3 Edeath 5 E	⊒Ectopic pregnanc	у	23e. Did 1 🗆	tobacco us	Month se contribute to a	Day Year the cause of death? bably 4 □Unknown
recolds, r.O. box 00/00,	le law requires that the death certilicate be executed has been signed by the attending physician and ge 2 should be detached for use as the burial-transit	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	c. Surfic shoot Due to (or as a consequence of d. 23c. If yes, outcome pf pregnance of depretation of depretat	ancy al death 3 Edeath 5 E	⊒Ectopic pregnanc	у	23e. Did 1 □ 24a. Was	tobacco us Yes 2	Month se contribute to to to 3 □ Pro 24b. Were autorior to co	Day Year
lai necolus, r.O. Box 08700,	in: The law requires that the death certilicate be executed ifficate has been signed by the attending physician and or, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions My for tending Anema a	c. Surfic shoot Due to (or as a consequence of d. 23c. If yes, outcome pf pregnance of depretation of depretat	ancy al death 3 Edeath 5 E	⊒Ectopic pregnanc	ven in Part I.	23e. Did 1 □ 24a. Was auto perf 1 □ Yes	tobacco us Yes 2 [I an psy ormed? 2 [I No	Month se contribute to a	Day Year the cause of death? bably 4 □Unknown
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SIOII OI VIIAI NECOIUS, F.O. BOX 00/00,	tending Prysician: The law requires that the death certilicate be executed earth confined by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Superior Conditions on the conditions of the	ancy al death 3E death 5E sulting in the u	□Ectopic pregnanc □ Other (specify) _ nderlying cause give nt 3□ DOA Other 28c. Inju Wo M 1□	ven in Part I. 26. Place of Deaner: 4 \(\text{Nursing First Pry at rk?} \)	23e. Did 1 □ 24a. Was auto perfi 1 □ Yes ath (Check only) thome 5 □ Res 28d. Describe	Yes 2 The same of the same of	Month Se contribute to to to to to to to to to to to to to	Day Year the cause of death? bably 4 □Unknown opsy findings available ampletion of cause of 2 □ No
Division of vital necolds, F.C. Bux 66760,	Ital of Attending Prysician: The law requires that the death certificate be executed rs after death. Is after death. It Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not determine	c. Sup Fice Mode Due to (or as a consequence of the	ancy al death 3 L jeath 5 L sulting in the u BER/Outpatier 28b. Time o Injury ome, farm, str	DEctopic pregnanc Other (specify) Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderl	ey ven in Part I. 26. Place of Dea ner: 4 □ Nursing H ry at rk? IYes 2 □ No	23e. Did 1	Yes 2 Tho ppy 2 Tho promed? 2 Tho one) idence 6 how injury	Month se contribute to to to to to to to to to to to to to	Day Year the cause of death? bably 4 □Unknown opsy findings available mpletion of cause of 2 □ No ify) al Route Number,
DIVISION OF VICE THE DAY 00/ 00,	he hospital or Attending Physician: The law requires that the death certilicate be executed in 24 hours after death. The fact that this certificate has been signed by the attending physician and he Funeral Director. After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions Anema a 25. Was case referred to medical examiner? 1 □ Yes 2 □ No 27. Manner of Death 1 □ Natural 5 □ Pending investigating investigating investigating and the properties of the properti	c. Superior Composition on the case of the contribution on the case of the cas	ancy al death 3E death 5E sulting in the u BER/Outpatier 28b. Time of Injury owne, farm, str	DEctopic pregnance Other (specify) Inderlying cause give Inderlyin	ey ven in Part I. 26. Place of Dearer: 4 □ Nursing Herry at rk? 1 Yes 2 □ No ime, date and place	23e. Did 1	Yes 2[Tana) an ppsy omed? 2[Tho one) idence 6 how injury cause(s) a	Month se contribute to to the second	Day Year the cause of death? bably 4 □Unknown opsy findings available ompletion of cause of 2 □ No ify) al Route Number,
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			For State	State of Maryl	_	artment of H		nd Mental Hy		007	29700	
		4.1	1. Decedent's Name (First, Middle, Las		/ 11 00	Timodic or	Douth	2. Date of De	eath		3. Time of Death	-
44	Physici /Medic		Amelia F. Stree	tt				Septem	ber 7,	Year 2007	1:55AM M	
	Examin	1000	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of			nty of Death	1-:001	
		ш	Gilchrist Hospid	ce		Towson	n		Ва	altimo	re	
å	Funeral		Social Security Number 6. Security Number	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		Min. (Month, Di	ay, Year)	9. Birthp	place (State or Foreign	-
Н	Director		213-42-4220	9	7 Yrs.			Apr 19	, 1910		yland	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation					10d. Inside City Limits	_
	farylan f show ed at	ō	MD Baltimor		Dhaa	m i vr					1 ☐ Yes 2 ☐ No	
	the 128a-	rect	10e. Street and Number	e	Phoe	10f. Zip Code			10g. Citizen	of What Cour		_
	with 3a or t be	Ö	14615 Old York Ro	nad		211	131		3	USA		
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ther, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever	n U.S. 13.			n? (Specify Yes or No Puerto Rican, etc.)	D- 14. F	Race - Americ		-
9	or Ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐ Yes 2 X No If Yes, Give				Puerto Rican, etc.)		Black, White,		
03	ral", c	l by	3 X Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spe	cify: whi	te	
21215-0036	72 hc natu dical	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occup	durina most d	of working	16b. Kind of	f Business/In	dustry	
21	ithin ne. nan "	ğ.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		han	lthcar	• •	
	led w tygie her ti nt, th		17. Father's Name (First, Middle, Last)	0	licei	nsed prac		s Name (First, Middle	1			_
anc	be fi	B	Fred Edward Gra	afa				Magdalina		iairie)		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryls to f Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ပ္	19a. Informant's Name/Relationship (7		19b Maili	na Addrass (Straat		or Rural Route Numl		un Stata Zir	Cadal	_
Ma	d 2 s th an t7 is r traur							d Phoenix,	-	vii, State, 21, 1131	Code)	
	1 and 2 Health em 27 i		Amelia Griffey/da 20a. Method of Disposition		b. Place of Dispo	osition (Name of	ī	Date		on - City or To	own, State	-
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify		cemetery, cre	matory or other pla	ce)			•		
Ė	artme artme ortan injur	1	21. agriculare of Funeral Service Licen	000	_2	2. Name and Addre	ess of Facility	1 (55 **	n 1.1	500		
Ba	permi Depa Impo any ir		Mona 3/	Direct		tate Anat altimore,	-	ard 655 W	. Balti	more S	street	
5			23a. Pant. Enter the disease, or comp	olications that caused the					arrest,		Approximate Interval Between	
	Physician	8.7	shock, or heart failure. List only immediate Cause (Final		BB 0.	ا ما الم	-+1			- 4	Onset and Death	
	/Medical		disease or condition resulting in death)	a. Schem Die to (or as a cor	sequence of):	rei oni	1 00 200 10	7			9013	-
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, 00	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ä	resulting in death) Last	Due to (or as a cor	sequence of):							
8760,	ate b	dical		d					-			_
9	death certific attending p	Med	IF FEMALE:	20- 16								
Box	ath cather	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pro	Fetal death 3	⊒Ectopic pregnanc	у		100	Date of delive Month	ery Day Year	
	the de	ysic	in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	4□Pregnant at time 9□Unknown	or death 51	Other (specify)						
P.0	that the de sed by the a detached		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?	-
Records,	w requires that been signed to should be det	d by						1 🗆	Yes 21 No	o 3∐ Prol	bably 4 Unknown	
Ö	w req beer shou	Completed						24a. Was	an 24	lh Were auto	opsy findings available	
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or Vital	Physician: this certificaral director, I	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA Oth	or.	sing Home 5 - Res		Other (Specie	n hospire	-
	g Phy er thi eral (27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe			1977 1237 13	-
io	Attending r death. ector: After by the fune	ațio	1 Accident 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury		Yes 2 □ No	0				
Division	I or Attencather death Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - huilding, etc. (Sp	At home, farm, st	reet, factory, office			(Street and Nu	mber or Run	al Route Number,	
Ö	talonrs after allons al	Certification:										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only & Medical Exan	ysician: To the best of my niner: On the basis of exam								
	the hin 24	Medical	one)	and manner stated.		100.11						_
	5 Viti	2	29b. Signature and title of certifier	~+m		29c. Licens	· ススカー	2	29d. Date sig	gned (Month,	7 200	
						10:			0410	TIOCY	1 1201	_
				ES WO 67	(Item 23a) (Type,	Charles	555	3 TOWSON	MO	21200	+	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 7 20	32 Registrar's S	ignature	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** STONE CALVIN **JOSEPH** SEPTEMBER 12,2007 12:52AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b, City, Town, or Location of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year) April 18,1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours 1**X** XM 2□ F Mary I and 215-14-8739 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside Cify Limits 28a-f show 1 □Yes aryNo Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8820 Walther Blvd #4318 USA Funeral . Was Decedent Ever in U.S. Arryed Forces? 1∑Nes 2 □ NoWW I I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes XXNo White þ Specify Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Vice President Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph P Stone Alice Graves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey M Stone Son 609 Spinnaker Way Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20c. Location - City or Town, State GreenMount Crematory 19/14/07 Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funer 1 Se 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. East only one gause on each line. Immediate Cause (Final Physician SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any leading L. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death g☐Unknown 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No g □ Unknown signed be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 1 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate has be rector, page 2 s autopsy perforn To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 28a. Date of Injury uneral . Manner of Death 1 Natural 2 Accident 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KHOO.

RANCIS

OSLER DRIVE

29c. License number

D3Ø263

TOWSON. MARYLAND

29d. Date signed (Month, Day, Year) 9-12-0

and manner stated.

7601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12 Tyler 09 2007 7:45p.M Charles Edward /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Marley Neck Health & Rehab Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1₩ M 2□F Months Days Hours Director 69 213-34-9671 02 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show cical Examiner must be notified at MD NA Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with the and Mental Hygiene.
Is marked other than "natural" or theme 23a or 1 3021 Seamon Ave 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event John E. Tyler Martha B. Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Herman A. Tyler-brother 502 Roundview Road, Baltimore, Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 9/19/07 Arbutus, Md 22. Name and Address of Facility March F/h West 21. Signatura of Funeral Service Licensee 4300 Wabash Ave, Baltimore, 21215 P. ft1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immy diate Cause (Final disc ase or condition sulting in death) aldre Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed pu Due to (or as a consequence of) buriaphysician the burial Box 68760. Physician/Medical that the death certificate as attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9☐Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performe certificate ₽ No Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: Ar completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and a me

31. Date filed (Month, Day, Year)

SEP 1 7 2007

Annapolis

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0023 Gerald W. Turner, Sr. 09-17-2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Upper Chesapeake Hospital Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1**⊠**M 2□F 217-38-7470 66 10-29-1940 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1292 Pearson Place 21017 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 2 Medical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clyde Turner Sarah Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1292 Pearson Place Belcamp, MD 21017 Joan Turner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 09-21-2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final croiac HOUTE disease or condition resulting in death) Due to (or as a consequence of): MARCON CUTE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) UDENTENSID Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🖳 Natural 5 ☐ Pending investigation

Examiner The law requires that the death certificate be executed burial-transit and P.O. Box 68760, physician Physician/Medical the ed by the attending detached for use as signed t Division or Vital Records, cate has been signal page 2 should be Completed or Attending Physician: Be P this completely filled in by the funeral Certification: Director:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

and 2 should be filed within : ealth and Mental Hygiene.

Pages 1 and 2 tment of Health?

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Gerald Turner

the Hospital

within 24 hours a To the Funeral I 2

> State Registrar

Medical

31. Date filed (Month, Day, Year)

SEP

17

200

29b. Signature and title of certifier

6 □ Could not be

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Gajistrar's Signature

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

Porcuile

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10 200 Rosa Belle Thompson /Medical County of Death 4a. Facility Name (If not institution, give state 4b. City, Town, or Location of Death Examiner alen Burrie If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □XF 437-22-6594 12-24-1920 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene, instrument of Items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. death with the Marylar ty∑Yes 2 No Director Sullivan **Bristol** TN 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 37620 U.S.A. 26 Crown Circle Drive Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. ☐ Yes 2 X No Yes, Give 'ear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F is marked of Pages 1 and 2 should be Alzina Guillory Neles Guillory ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles Thompson / Son 37620 120 Elk Road Bristol, TN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09-15-2007 Bristol, TN Glenwood Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Srv 21. Signature of Funeral Service Licensee and 21061 Glen Burnie, MD 1 2nd Avenue SW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5e **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an s certificate has be lirector, page 2 s performed 2 X No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA r a after death. I Director: After this of in by the funeral di 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Magner of Death 28c. Injury at Work? Medical Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours aft

To the Funeral DI

completely filled in

State

Registrar

DHMH 17 Rev 1/2001

AciA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

30

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:05 PM UNGLESBEE Emma 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SYKESVILL CARROLL STREET CHURCH 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 18 Director 0152 DEC 31 Usual Residence of Decedent 10d. Inside City Limits t be notified at 10a. State 10c. City, Town or Location 1 XYes 2 □ No CARROLL Director SYKESVILLE 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or amy Injury or other traumatic event, the Medical Examiner must be 1 once. CHURCH STREET 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) HOWARD MARTHA BOSWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STALCUP LANE, BUTLER, TN 37640 CAROL BAKER NAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 9/18/2007 MARRIOTISVILLE, MD RESTLAWN Mem. GAR. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility JNZVMBNN EH4 MON. Co. 21. Signature of Funeral Service Licenses 6028 SYKESVILLE ROOM ENDERS BURG MO 21784 23a. Bart. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** alzheimers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown NIA 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No NIM nia 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the NIA 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 6190 George ta31. Date filed (Month, Day, Year)

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Elders bury

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ams ember 14,2007 /Medical 4a. Facility Name (If not institution, dive street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Dactingre hearn and 7. Age (In yrs. last birthday) 82 Yrs. 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 F Hours Min. 219-14-3564 Director inia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No notified Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 2 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc other traumatic event, the Medical Examiner 1 Yes 2 Vo If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ō 2 No Completed by 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) gur than Elementary/Secondary (0-12) College (1-4or 5+) Nurse NIA of Health and Mental Hygin Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mb, 21228 nieco Ca da 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I-Important: If ite any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -17-200 netro 4 Donation Other (Specify) 21. Signature of neral Se 21229 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or indition **Physician** disease or modition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) cate has been signed by the a page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 ₩onknown 1 ☐ Yes 2□ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 110 Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 27. Manner of Lat 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Uniural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 7 2007 Registrar

			1 - For State Registrar	State of Maryla		artment of F			en2007	29707
	Physici /Medic		1. Decedent's Name (First, Middle, La Robert O		eippe	rt		2. Date of Death Month	6 2007	3. Time of Death 5: 30 M
}	Examin	er		ealth+Reha	b.Cente	c Gle	r Location of Death	ie	A A Co	٠.
	Funeral Director		5. Social Security Number 216-24-6447 Usual Residence of Decedent	7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) - Cor	nplace (State or Foreign untry) ryland
	Maryland -f show	tor	10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	3a or 28a	Funeral Director	10e. Street and Number 8012 Escalon Avent		abadena –	10f. Zip Code 21122		10g	J. Citizen of What Cou	•
36	rs after deatl I', or Items 2 Naminer mur	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ◘ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any highly or other treumatic event, I're Medical Examinational Le mullied at ance.	Completed t	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of worl	king 16	b. Kind of Business/l	ndustry
and 21	be filed water Hygien sid other the event, In	Be	17. Father's Name (First, Middle, Last	,		rinter		ne (First, Middle, Ma		
Maryland	d 2 should the and Men. 7 Is marked treumatic	은	Harmanus 19a. Informant's Name/Relationship (Linda C. Stencil	Type, Print)		g Address (Street		ral Route Number, C	MO: City or Town, State, Zifaryland 2	
altimore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Special	20b	. Place of Dispo cemetery, cren	sition (Name of natory or other place		Date 20	c. Location - City or 1	
Balti	permit. I Departm Importer any Inju		21. Signature of Funeral Service Lice						ne, P.A. Maryland	
	Pnysician /Medical Examiner		sheck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a.C.E.R.E.B.R. Due to (or as a conso	eath. Do not ento		ng, such as cardiac			Approximate Interval Between Onset and Death
8760, ~	icate be executed physician end s the burial-transit	dicai Examiner	If any, leading to immediate cause. Enter Undergring Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consi Due to (or as a consi						
.O. Box 6	The law requires that the death certific ate has been signed by the attending pi page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deli	very Day Year
rds, P	w requires that been signed k should be det	by	Part II. Other significant conditions	contributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,		Completed						24a. Was an autopsy performe	prior to c death?	topsy findings available ompletion of cause of
Zii	ysicien: is certific director,	o Be	25. Was case referred to medical examiner?	Hospital:		Oth	er /	th (Check only one)	. 50.	
o	ding Phys h. After this funeral di	-	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. injun	y at	28d. Describe how	ce 6 □Other (Specinjury occurred	uty)
Division of	or Attending Physiclen: after death. Director: After this certific in by the funeral director.	Certification;	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	OB Bloom of Injury At	home, farm, str		K? Yes 2 ☐ No	28f. Location (Stree City or Town,	et and Number or Ru	ral Route Number,
ā			29a. Certifier 1 Certifying Pl	nysician: To the best of my k	nowledge, death	occurred at the tin	ne, date and place,	, and due to the cau:	se(s) and manner as	stated.
	To the Hospitel within 24 hours To the Funerel completely filled	Medical	one) 29b. Signature and title of certifler	and manner stated.	mation and or in	29c. Licens	e number	29d	. Date signed (Month	
	1,		30. Name and address of person who			Print) RAI-	1104 TIMO R	E MD	21226	200-1
	i.\	to	31. Date filed (Month) Pay Year)	32. Tegistrar's Sig	INUE		,			
	Registr		SEP 17	32. ************************************	H A	meles				

07-06982 Jean Witherspoon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 29708 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day September 8, 2007 1425 hrs Medical Examiner Jean Witherspoon 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death 1102 Druid Hill Avenue Apt 903 Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Numberunk 6. Sex **Funeral** 7. Age (In vrs. last birthday) Months Days Director Country)Maryland 1 M 2X F Yrs 58 1949 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show MD Baltimore with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1102 Druid Hill Avenue #903 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. White, etc. Armed Forces' 1 Never Married 2 Married Yes ō 4 X Divorced If Yes, Give Yea Yes' 2 X No specify: Specify: black Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after
Department of Health and Memtal Hygiene.
Important: If item 27 is marked other than "natural",
injury yn other tranmatic egent, the Medical Examiner. 20 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 12 salesperson discount store 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Wellington Rose Edna Lane 19a. Informant's Name/Relationship (Type, Print-) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wellington Rose Jr/brother 6492 Mt. Vernon Lane Glen Burnie, MD 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Donation 5 X Other Specify: in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Raltimore, MD 21201
Approximate
Approximate Signature of Fune al Service Licensee Ronald S Director Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximata Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially-list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ned by the attending physician a detached for use as the burial -UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the outer. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✓ Yes No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) (Specify) Homicid 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME September 9, 2007 30. Name and address of person who completed cause of Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Yeer) 2007 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #30,perDVR,g871, 9/17/07 $_{
m TT}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** Christina Marie Wissel Sept. 16, 12:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 29, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 97 1910 **Director** 216-10-2193 MD Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√7 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Saint Luke Circle 21158 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event; the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Galster Blanche Palmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Edwin Wissel, Jr. Son 412 Butler Road, Glyndon, MD 21071 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Bernoval from State Carroll Cremation 9-17-07 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been sig 2☑No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 ∐ Yes 2 No 2 □ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation after death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital o within 24 hours aft To the Funeral Di

P.O. Box 68760,

State Registrar

Mahboob Ashraf, MD Carroll Hospital Center, Westminster, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year)

HB0013

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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	1 - For State Registrer	State of Ma		artment of H <i>rtificate of L</i>		Mental Hyg	iene _{99. No.} 2 () (7 2971
nysician Medical	Catherine	Patricia	Zegowitz			2. Date of Deat Sept 13	, 2007	3. Time of Death 12:42 P
xaminer	4a. Facility Name (If not institution, 6606 Hallam Dr 5. Social Security Number	rive	(In yrs. last birthday,	4b. City, Town, or Upper Ma				f Death George's Birthplace (State or Fore
neral ector	578 48 1892 Usual Residence of Decedent	1□M 2XXF 71		Months Days	Hours Min.	NOV 2,	19 35	Washington Do
ust be notified at	Maryland Prince	George's	Upper Ma	rlboro				10d. Inside City Lim 1 ☐ Yes XX
ustber	OGOO HATTUM			10f. Zip Code 20772			Og. Citizen of Wr United	States
evant, the Medical Examiner must Be Completed by Funeral	11. Marital Status 1 □ Never Married XX Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? d 1 Yes 2 N If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2∰Xo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black,	American Indian, White, etc. White
t, the Medical I	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor	rking	16b. Kind of Busi	
evant, I Be Co	17. Father's Name (First, Middle, La		TIUMA	n Resourc		ne (First, Middle, N)
	Michael 19a. Informant's Name/Relationshi	McVearry (Type, Print)	19b. Maili	ng Address (Street a	nd Number or Ru		ine Far	
or other traumatic	William L. Zego		d) 6606	Hallam Dr	rive, Upp	oer Marlb		20772
ry or off	20a. Method of Disposition 1 △Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		20b. Place of Dispo	sition (Name of natory or other place ion Cemet	Sept 17	Date 2	20c. Location - C Clinton	ity or Town, State
any injury or o	21. Signatur of Funeral service Li	office of	22		s of Facility Lee	e Funeral	Home, Ir	nc 6633 Old 20735
cian lical	23a Part. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the one cause on each line a	j.	er the mode of dying		-	*	Approximate Interval Between Onset and Death
the burial-transit	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
<u>م</u> ھ	Part II. Other significant conditions	s contributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	_/	ute to the cause of death?
Completed						24a. Was an autopsy perform	ed? prid	ire autopsy findings availa or to completion of cause of th?] Yes 2 \(\sum \text{No} \)
ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 Too 27. Manner of Death 1 Tatural 5 Pending 2 Accident investigat	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time of	t 3 DOA Other	4 Nursing Ho	th Check only one ome 5 2 esider 28d. Describe how	nce 6 Other	
Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injur- building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number State)	or Rural Route Number,
S 0								
letely filled	(Check only 2 Medical Ex	and manner state	ed.	ostigation, in my opi				\- <i>\</i>
completely filled in by the funeral director, page 2. Medical Certification; To Be Compl	Check only 2 Medical Ex	and manner state	ed.	29c. License			d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible lnk, Ensure All Copies Are Legible.

AMEND, ITEM#5, perFH, G871, 9/25/07, WS.

		State Registrar			nd Dep Ce	rtificat	te of L	Jeatn		Re	g. No.		
nysicia		Decedent's Name (First, Middle,	Last)							Date of Deat Month	h Day	Yeer	3. Time of Death
Medica	al -	Edgar T.	Biggs	Jr.		45 035	T	1 continued D		ept.	9	2007	11:15 a. ^M
camine	r	4a. Facility Name (If not institution,						Location of De	eatn			ounty of Dea	
eral		Moran Manor No 5. Social Security Number 219-14-6213	. Sex		s. last birthday)	If Unde	r 1 Year	nport If Under 24 F	Hrs. 8. C	Date of Birth		Allega 9. Bi	rthplace (State or Foreign
ctor		219-14-6213 -213-14-6213	1 M 2 □ F	83	Yrs.	Months	Days	Hours M	in. Ju	Month, Day,	,1924	4 Cr	country)
	-	Usual Residence of Decedent		100 (Sib. Taum and								104 10-14- 01-11-16-
		10a. State 10b. County		100.	City, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Andrew Comment of the	Director	WV Mine 10e. Street and Number	eral		Keyse		p Code			1	On Citize	n of What C	
		Rt. 1, Box 14	7			1 0,1 2,4	2672	06			US		
	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Dece		spanic Origin? n, Mexican, Pu	(Specify	Yes or No-		. Race - Am	erican Indian,
	F	1 Never Married 2 X Marrie		2 X No		1 Yes, spe		Specify:	Jeito Mica	n, etc.)	S	Black, Wh	ite, etc.
:	d by	3 Widowed 4 Divorced	Year or I	Dates:				, ,		- 9		WI	nite
	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usu kind of wo DO NOT u	ork done d	urina most of 1	working		16b. Kind	f of Business	s/Industry
	d L	Elementary/Secondary (0-12)	College	(1-4or 5+)				ırtment				Paper	Mi11
ď	Be C	17. Father's Name (First, Middle, La	ist)				Jupe	18. Mother's i		st, Middle, N			I I de de de
	은 -	Edgar T. Biggs	s, Sr.					Kate	т. (Ours			
-		19a. Informant's Name/Relationshi	o (Type, Print)		19b. Maili	ng Addres	s (Street a	nd Number or	Rural Ro	ute Number	City or 1	Town, State,	Zip Code)
	-	Laura L. Biggs	Wife	201	Rt.	1, B		7 Key	ser,		2672		Town Chair
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3		State	cemetery, cre	matory or	other place	. let	pt. 1	3	20c. Loca	ation - City o	r Town, State
2.0	-	 4 □ Donation 5 □ Other (Special Signature of Funeral Service Li 		Po	tomac M			ardens	-			yser,	WV
once		21. Signature of Purenal Service di	12/	, FIT	* "			in Str				L Home VV 26726	
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an		shock, or heart failure. List o		each line. Co Ronn	an An	len	R	seize					Interval Between Onset and Death
al		disease or condition resulting in death)	_ d	(or as a cons		/							gens
er		Sequentially list conditions	h										
-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dué to	(bras a nonse	equalitie of):								
	Examiner	that initiated events resulting in death) Last	c.	(or as a conse	aguanca of):		_	_					
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:	edical		d										
1	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	atcome of preg	nancy	7=					23	d. Date of de	elivery
	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2∏Fe inant at time of		□Ectopic p □ Other (s)						Month	Day Year
,	y h	9 🗆 Unknown											
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	Completed								-	24a. Was a autops	v	24b. Were a prior to death?	autopsy findings available completion of cause of
										perform		1 ☐ Ye	s 2 No
0	Be	25. Was case referred to medical examiner?	Hospital: 1				Othe Othe	26. Place of I					
1	: To	1 ☐ Yes 2X No 27. Manner of Death		of Injury of, Day Year)	☐ ER/Outpatie 28b. Time o		28c. Injury Work	4 M NUISIII		Describe ho		Other (Sp occurred	өспу)
	Certification:	1 Natural 5 Pending 2 Accident investiga		nth, Day Year)	Injury	М		(? /es 2 □ No					
	LILIC	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place	e of Injury - At	home, farm, st	reet, factor	ry, office			Location (St City or Town		Number or f	Rural Route Number,
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	edical	(Check only 2 Medicel E	Physicien: To the	e best of my k	nowledge, dear	th occurred	at the tim	e, date and pl	lace, and o	due to the ca	ause(s) a ate and p	nd manner a	as stated. ue to the cause(s)
	Med	one)	and ma	nner stated.									nth, Day, Year)
		29b. Signature and title of certifier)		29	c. License			2			, Day, rear/
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			no completed on.	ise of death (It	em 23a) (Type	Print)							
10		30. Name and address of person w Jesus Tan,		Broad		ostbu	iro	MD 2	1532				

State of Maryland / Department of Health and Mental Hygien 2007

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 4:45 A. M September 7, 2007 Asa Lincoln Colson, IV /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Calvert Memorial Hospital Prince Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1**X** M 2 □ F 47 02-02-1960 New Jersey 155-46-4593 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No MD Lusky Director Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Items 23a or the Medical Examiner must be r 520 Cody Trail 20657 United States Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Software Architect Computer and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Vivian Parsons Asa Lincoln Colson, III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 520 Ccdy Trail, Lusby, Maryland 20657 Robin A. Colson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/8/2007 Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. te P. O. Box 600, Lusby, Maryland 20657 Dutt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE ANCREATIT disease or condition /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? ′es 2 ☐ No certificate 10 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 10 HUSPITAL 100 3 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 107 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Year Month 8:01 M Sr. September Crites Franklin 2007 Jessie /Medical 4A Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep 18, **Funeral** Days Hours 2 🗆 F Director 213-22-3223 Usual Residence of Decedent death with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show M-dical Examiner must be notified at Cumberland Allegany 1 ✓ Yes 2 No MD Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21502 USA 14106 Rowley St., SE Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumattc event, the Medical Examines 1 KYes 2 □ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify. þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kelly Springfield Electrical Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Weise Crites Jessie Gordon Crites ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zin Code). 794 Oak Stump Dr. Millersville MD 21108 19a. Informant's Name/Relationship (Type. Print) Frankie Crites son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Davis Memorial Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/12/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name Scarpelli Fulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immulate Cause (Final dise e or condition resulting in death) Physician neumoni /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Re Tu JC0. 24787 Glen MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 32. Registrar's Signature Wedica Hospital Drive 301 ti more 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

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			State of Maryland / Department of He State Registrer Certificate of D	ealth and Me <i>leath</i>		en2007	29715
			1. Decedent's Name (First, Middle, Last)		. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic	_	CONCETTINA MARIE CARPENTIERE			10 200	
*	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L	ocation of Death		4c. County of De	ath
			GENESIS ELDERCARE CENTER LA PLA			CHAR.	
	Funeral		Months Days	Hours Min.	Date of Birth (Month, Dey,	Yeer) 9. B	inthplece (Stete or Foreign Country)
	Director	1	042-01-4870 101 Yrs.	MAY 18	,1906 C	ONNECTICUT	
	yland now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mar a-fal	tor	MD CHARLES NEWBURG				1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number 10f. Zip Code		109	g. Citizen of Whal (Country?
	ath w	rai	15225 HATTON LANDING DRIVE 20664			U.S.	
	er de	Funerai	11. Marital Slatus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of His If Yes, specify Cuban,	panic Origin? (Speci , Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Hace - An Black, Wi	nerican Indian, nite, elc.
3	hours after death with the Maryland turel', or fleme 23e or 28e-f show al Examinational be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼No If Yes, Give 1 □ Yes 2 □ No Year or Dates:	Specify:		Specify:	WHITE
215-0036	72 hours natural', dical Exc	led	15. Decedent's Education 16a. Decedent's Usual Occupation	ion	10	6b. Kind of Busines	
212	d within 72 ho piene. r than *natur the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done du life. DO NOT use retired)	iring most of working			
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aryland	e d a b	Be		18. Mother's Name (7
2	should nd Men marke	2	ANTONIO MARINO	GIUSEPP:			
<u> </u>	C		19a. Informant's Name/Relationship (Type, Print) DAUGHTEK CONSTANCE CARPENTIERE				
	s 1 and f Health Item 27 other tr		20a Method of Disposition 20b. Place of Disposition (Name of	Dat	NG DR .	NEWBUR 0c. Location - City	D20664 or lown, Slate
<u>ē</u>	00		1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) • Cometery, crematory or other place) • ROSE HILL MEM. F	SEPT			Warter Vicency
altımore,	permit. Peg Department Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address	of Facility		ROCKY H	SERVICE P.A
'n	Per Per G		Jour 800641 5635 WASH				
-			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac or i	respiratory arres	sl,	Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition	ELERN	125		Onset and Death
	/Medical Examiner		resulting in dealh) Due to (or as a consequence of):	0. 740	1		. 0
	Examine:	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	NIMR.	177	iAlé.	tylors.
	ted nsit	nine	Cause (Disease or injury				
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ROX	death certific e attending p id for use as	ician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of o	delivery Day Year
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ita		Be C	25. Was case referred to medical	26. Place of Death (
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0	ding Phy h. After thi funeral		27. Manner of Death 1	?	d. Describe hov	w injury occurred	
<u> </u>	tendi Jeath tor: A	cati	2 Charles 6 Could not be	es 2 No	If Location (Str	not and Number or	Rural Route Number,
Division of	after of Direction by	Certification;	4 Homicide determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	20	City or Town,	State)	nuiai noute tvuiliber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time	e, date and place, an	d due to the cau	use(s) and manner	as stated.
	he Ho in 24 i he Fu	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opi and manner stated.	nion, death occurred			
ì	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License	number	29	d. Date signe (Mo	onth, Da , Year)
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	2	9	30. Na e an address p son who completed cause of death (Item 23a) Type,	1A. n.	ar.	nAd.	70602
	Sta	te	H. Atte filed (Month, Day, Year) Registrar's Signature	1001	177,	10 10	
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State of Maryland / Department of h	lealth and Mental Hygie	end UU/	25) [ı

		1 - State Registrar		Ce		of Death	,	Reg. No.				
Diam'r.		1. Decedent's Name (First, Middle					2. Date of De Month		Voor	3. Time of Death		
Physic /Medi		Daniel Wi	lliam Cresce	nzi, S	r.		Augus	Day st 26, 2	Year 007	5:52 P M		
Exami		4a. Facility Name (If not institution,				m, or Location of Deat		4c. County		ndel		
			Medical Center 6. Sex 7. Age (In yrs.	forma de feriendo este est	Annaı If Under 1 Y		100					
uneral irector		579-54-2933	6. Sex 1XXM 2□ F 7. Age (In yrs. 64	Yrs.		ays Hours Min.	8. Date of Bir (Month, Da Aug • 25	1943	Cour	lace (State or Foreightry) DC		
be notified at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	, Town or Lo	ocation				1	0d. Inside City Limits		
	jo	MD Anne Ar	rundel Co. Ar	napol:	ic					1 ☐ Yes 2 No		
2	Funeral Director	10e. Street and Number	under co.	парот	10f. Zip Co	de		10g. Citizen of	What Cour	ntry?		
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aminer must b	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.		of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No		e - Americ			
		1 Never Married 2 Marri			1 ☐ Yes 2 🛛		o nican, ecc.)		ck, White,			
	d by	3 ☐ Widowed 4 ₹ Divorced	Year or Dates:						w Whi			
	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a. Dece	dent's Usual O	ccupation one during most of wor stired)	king	16b. Kind of B	usiness/Ind	dustry		
	l mc	Elementary/Secondary (0-12)	College (1-4or 5+)					TI. T				
		17. Father's Name (First, Middle, L	ast)		irefigh	18. Mother's Nar	ne (First, Middle,	Fire D		ment		
	To Be	William R. Cres	cenzi			Marth	a T. Sch	losser				
	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailir	ng Address (St	reet and Number or Ru			State, Zip	Code)		
		Daniel W. Cres	cenzi, Jr. (Son)	4133	Conte	Road, Loth	nian, Ma	ryland	20711			
r other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	20b. P	ace of Dispo	sition (Name o	f Aug.	Date 30	20c. Location	City or To	wn, State		
ury or o		4 ☐ Donation 5 ☐ Other (Sp	3 Chelloval Ilolli State		L1 Ceme	F		Suitlan	d. Ma	rvland		
once.		1. Signature of Fundame Lee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A 8125 Southern Maryland Blvd., Owings, MD 20736										
a		No.	- Lee	81	L25 Sou	thern Mary	land Blv	d., Owi	ngs,	MD 20736		
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the death only one cause on each line.	. Do not ent	ter the mode of	1 .				Approximate Interval Between		
ian		Immediate Cause (Final disease or condition	a. Due to (or as a consequ	LARD	Nich 1	1750	YLG:	000		Onset and Death		
cal ner		resulting in death)		1								
	-	Sequentially list conditions	b. Que to (or as a consequ	(he	72~							
П	E E	Sequentially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≥ do to (oi do d consequ	0	201							
	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	e of):								
		a Rhymhoid permition										
	Medical						_					
10.100		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		DEctopic pregna	ancy			te of delive	•		
De detached id	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify			Mo	nth	Day Year		
	Phy	Part II. Other significant condition		W1- 1- 1			60 D:44					
	1 by	Part II. Other significant condition	sa contributing to death but not rest	liting in the ur	nderlying cause	given in Part I.		obacco use cont es 2 □ No		e cause of death? ably 4 □Unknown		
	etec						-					
	Completed						24a. Was	SY	Were autor prior to con death?	osy findings available apletion of cause of		
	e Co	25. Was case referred to medical					1 ☐ Yes	2. No	Yes	2□ No		
	8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	R/Outpatien		Other: 4 Nursing H	- 0: n:					
	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	1 3LI DOA	4 ⊔ Nursing H njury at Work?	ome 5 Resid			")		
	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury		Work? 1 □ Yes 2 □ No						
	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of injury - At no	me, farm, stre	eet, factory, off	ice	28f. Location (S	Street and Numb	er or Rura	Route Number,		
	Cert	4 Li Homoldo	building, etc. (Specify)			City or Tox	m, State)				
(19)	edical	29a. Certifier 1. Certifying (Check only one)	Physician: To the best of my know xaminer: On the basis of examinat	vledge, death ion and/or inv	occurred at the	e time, date and place ny opinion, death occu	and due to the c	cause(s) and madate and place,	nner as st	ated. the cause(s)		
completely filled in by the funeral	Mec	29b. Signature and title of certifier	and manner stated.		29c Lic	ense number		29d. Date signe	d (Month I	Day Year)		
- 13		· CZAN	~ Q. A	^ *	10	7391	0)	9/	7 7	100		
		30 Name and address of pareces:	no completed cause of death (Item	220) (T	Drint)	- > 16		01	c +	10 +		
		Barry Rediaee				e Suite 201	Temple	Hille	MD 2	0748		
Sta	ite	24 Date Stad (Month Day March					. тешрте	111110,	1111 2	0170		
egistr	ar	AUG	3 0 2007	· K	Goral	20						

Division or Vital Records, P.O. Box 68760, Hospital or Attending

within 24 hours after

To the Funeral Dire

completely filled in b Medical

thours after death.

-uneral Director: A
ely filled in by the fu

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Mont

29b. Signature and title of certifier

Day, Year)

AUG 3 0 2007

6 Could not be determined

Registrar

and manner stated.

19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUllNan NO

gistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician

/Medical

Examiner

Funeral

Director

or 28a-1 show

or items 23a

netural',

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if item 27 is marked other than *! any njury or other traumatic event, the Next ORGS.

Baltimore, Maryland 21215-0036

Director

Funeral

δ

Completed

Be

traumatic event, the Medical Examiner must be notified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 0.071 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 1:50 pM Elaine Bise Doane 10 2007 2004mber 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Boons boro
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)
April 13,1918 Fahrney-Keedy Memorial Home
5. Social Security Number 6. Sex 7. Age (Ir Washington 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ XF Months 89 Yrs. Virginia 229-42-8421 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Rd. 21713 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Store 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Walker Bise Georgia Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Doane 743 Ashton Dr. Falling Waters,WV. 25419 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 12, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg,Md.21783 MO1414 AWIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final w disease or condition resulting in death) evelyovasco Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cue to (or as a consequence of) une tersion Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

the attending physicien and hed for use as the burial-transit

signed by t d be detach

certificate has b

After

Director

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Division of Vital Records, P.O.

the Hospital or Attending Physician:

death.

hours after within 24 hours a'

BLAINE

30ANE

Examiner

Physician/Medical

Completed

Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed

1 ☐ Yes 2 ☐ No 3 ☐ Probably ❤️ Unknown

2. No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes

26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner 1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 09-11-200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Waseem M.D. 1126 Opal Ct. Hagerstown, Md. 21740

Registrar

2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lalbot Memorial aston 8. Date of Birth (Month, Day, Year) Dec. 12, 1915 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Illinois Days Hours 1**⊠** M 2□ F 579-05-4873 91 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 8551 Duffers Dell 21629 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or Specify: White 1 ☐ Yes 210 No ģ 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Basketball Coach Private Education If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert J. Dwyer Catherine O'Connor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Plyers Mill Road, Silver Spring, MD 20902 Mary C. Mullooly/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or or ¥XBurial 2 ☐ Cremation 3 ☐ Removal from State Sept. 1, St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signatu o Funeral Se rvice Licensee 500 University Blvd, W., Silver Spring, 23a. Part1. Enter the disease, or comp cati shock, or heart failure. List only olde c ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 19PIRATION **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner GRAVIS MYASTHENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 🗌 Yes 2 No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a, Was an autopsy 2 No 1□ Yes ...spital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Thipatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) after death. 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 🗹 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Sport Duve

To the Luspital within 24 hours a To the Funeral D

State Registrar

29a, Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Monti

and manner stated.

WASHINGTON STREET, EASTON, MD 21601

D0059487

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007

Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) $\overset{\text{Day}}{24} \ 20\overset{\text{Year}}{07}$ Physician Barbara Diggs August 2:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 235 Farragut Rd. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 1 F Director 214-18-7048 86 Aug 8 1921 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh notified 1 Yes 2 □ No Director Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n 235 Farragut Rd. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Black. Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) Environmental Service Medical Center 7th of Health and Mental Hyg Item 27 Is marked other other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Diggs Elizabeth Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Doyle(Daughter) 235 Farragut Rd. Annapolis, Md. 21401 permit. Pages 1 at Department of Hea Important: If Item 3 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery clematory of other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Memorial Gardens 8-30-07 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. With a me Reddee of Eacil Sons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician METATTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed GOUT 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform HELICOBACTER 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 X Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 2025134 PAVERTON ST, #101, EDGENATER, MD, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 PRESSEY

31. Date filed (Month, Day, Year)

AUG 3 0 2007

mD,

Registrar's Signature

3169

Division or Vital Records, P.O. Box 68760,

usan Fleegle		- For State And Registrar	te of Maryland / end Item 17 & 1	Departm Bec er fih d	nent of Heal	th and Ment /23/07dhb		3. No. 200	
Physicia Medical Examin	L/E	Decedent's Name (First, Middle, I Susa	•	leegle			2. Date of Death Month September	Day Year	3. Time of Death 0239 hrs
		4a. Facility Name (if not institution,	give street and number)	100810	4b. City,	Town, or Location o		4c. County of Death	
Funeral		En route to Cumberland 5. Social Security Number 6.		(In yrs. last bi		berland der 1 Year If Unde	r 24Hrs. 8. Date of Birth	Allegany	hplace (State or
Director		184-52-4592		18	Yrs. Month	hs Days Hours	Min. 03/02/	1959 Foreig	n untry) MD
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
Maryland 28a-f show any d at once.	اةِ	PA Bedfo	ord		Hyndmai		140	g. Citizen of What Cour	1 X Yes 2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Öİr	10e. Street and Number 123 Locust	St			p Code 5545	10	USA	iuy?
ath with tems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Armed Forces?			ent of Hispanic Orig ify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
fter des l'', or i		3 Widowed 4 X Divor	1 Yes 2	X No	1 Yes 2	2 X No specify:		Specify: Whi	te
hours a	ed by	15. Decedent's Education (Specification)				I Occupation (Give I orking life. DO NOT		16b. Kind of Business/l	Industry
5-0036 led within 72 hou tygiene. other than "nati	Completed	Elementary/Secondary (0-12) 12	College (1-4 or 5	5+)	Lab	orer		Metal	
21215-0036 suld be filed within ? I Mental Hygiene. I marked other than it event, the Medics		17. Father's Name (First, Middle, Li	ast) Leydig			1	's Name (First, Middle, N		
2121 uld be fi Mental marked	o Be	William E. 19a. Informant's Name/Relationship	-Leydia	1	9b. Mailing Addres		Shirley H		e, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N fant: If item 27 is n or other traumatic	_	Michael L.	Fleegle -				.0. Box 567		
ore, ME ges I and 2 s of Health as If item 27 ther traums		20a. Method of Disposition 1 X Burial 2 Cremation	3 X Removal from Sta	ate crem	e of Disposition (Na atory or other place	e)	Date	20c. Location - City or	
Baltimore, permit. Pages I at Department of Het Important: If ite		4 Donation 5 Other Sper 21. Signature of Funeral Service Li		Dry R	idge Cem		09/07/2007		
Bal permi Depa Impo injur		Jeromy W. Heete	er per D		169 C	larence S	Harvey H. St., Hyndmar	. PA 15545	
Physician		23a. Part I. Enter the disease, or co failure. List only one cause or		the death. Do	not enter the mode	of dying, such as c	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	ı	Immediate Cause (Final disease or condition resulting in death)	a. Torso Injuries Due to (or as a conse	equence of):					Death
		Sequentially list conditions,	b						
	Ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse c.	equence of):					
ted Insit	Examiner	events resulting in death) Last	Due to (or as a conse	equence of):					
50, te be executed yysician and burial - transit	ledical	UNPENDED	d AMENDED Ite	em 21 p	er fh.g8	71,09/17/	07dhb		
Box 68760, e death certificate be the attending physic at for use as the burned for use	Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor		у			23d. Date of deliver	y Day Year
Ox 6876 eath certificate e attending phy for use as the l	cian	past 12 months?	4 Pregnant at	time of death	Fetal deathOther (Sp		c pregnancy	Month	Day Teal
BO) he deat y the att	Physician/M	Part II. Other significant condition	9 OHKHOWH	h but not recult	ing in the underlyin	ag cause given in Ps	art 23e Did to	bacco use contribute to	the cause of death?
s, P.O. Bo	ত্র	Part n. Other significant conductor		,	ing in the underlying	ig dadse given iii i	100	2 🗸 No 3 🗌 Pro	
ords, w requir	Completed						24a. Was a		utopsy findings available completion of cause of
teco The law ate has	gmo			-			perfor 1 Y Yes	med? death?	es 2 No
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?	Hospital:			26.Place of Death			
n of Vital I ling Physician: After this certifi funeral director,	의	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry 28t	Outpatient 3	DOA Other 4	28d. Describe</td <td>Residence 6 Other</td> <td></td>	Residence 6 Other	
on C ending sath. or: Af the fun	틽	1 Natural 5 Pendir	ng Sep 1, 2007	^(ear) 01	46 hrs	1 Yes 2 🗸	No Passenger s	single vehicle roll-	over accident
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	2 Accident Investi 3 Suicide 6 Could determ	not be 28e. Place of Ir			ry, office building, e	tc. 28f. Location (\$ or Town, \$	Street and Number or R state) o Road, Hyndman, P	ural Route Number, City
Di To the Hospital within 24 hours a To the Funeral	_ [29a. Certifier 1 Certifying Phy	vsician: To the best of m	y knowledge, o	leath occurred at the	he time, date and pla	ace, and due to the caus	e(s) and manner as sta	ted.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Exam	niner:On the basis of exa and manner stated.	mination and/o	r investigation, in n	my opinion, death or	ccurred at the time, date	and place, and due to t	he cause(s)
	Ž	29b. Signature and title of certifier	11 mi		2	9c. License number O.C.M.E.		29d. Date signed (Mo	
		30. Name and address of person w	yho completed cause of o	leath (Item 23a	a)	J.J.W.L.		2.5	
		Melissa Brassell, MD	Assistant Medica	l Examiner		Street, Baltimor	e, MD 21201		
Sta Regist		31. Date filed (Month, Day, Year)	2007 32. Segistra	r's Signature	Sporte	þ			
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State Registrar

Alsion of Vital Records, P.O. Box 68/60,	Attending Physician: The law requires that the death certificate be executed death.	ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	

			1 - State of M State Registrar	aryland / D		rtment of H tificate of L		Mental Hy	gien Reg. N	^e 2007	29723
	Physici		1. Decedent's Name (First, Middle, Last) CHARLES	FERGU	USO:	N	_	2. Date of De Month	ath Da	ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Deat			9, 2007 c. County of Dear	
	_xamm		35 Walton Road			Hunti	.ngtown			Calve	art
	Funeral			ge (In yrs. last birth	nday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	h .		hplace (State or Foreign buntry)
	Director		234-52-6576 ¹ X ^M ² □ F	71 Y	rs.	Months Days	Hours Min.	Feb. 2	y, Year 4 , ´		st Virginia
/land	at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Loc	ation					10d. Inside City Limits
e Man	a-f sh tiffied	Funeral Director	MD Calvert	Hunt	ing	town					1 □Yes 2X No
Ŧ	or 28 e no	ire	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?
th wi	23a Ist b	al	35 Walton Road			200	639		Un	ited Sta	ates
dea .	s me	ner	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of Hi	spanic Origin? (S	pecify Yes or No	-]	14. Race - Ame	
filed within 72 hours after death with the Maryland	ar Hyglene. ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Pater	No VIETNAM- ERA		☐ Yes 2XNo	Specify:	to riicari, etc.)		Black, Whit	white
72 ho	'natur dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a, D	Decede Give k	ent's Usual Occupa ind of work done d O NOT use retired,	ation Juring most of wo	rking	16b. I	Kind of Business	Industry
within	than '	Juno	Elementary/Secondary (0-12) College (1-4or s	o+)		o not use retired, der) "	J	_	onstruct	-ion
- m -	and Mental Hyglene. is marked other than aumatic event, the M	Be C	17. Father's Name (First, Middle, Last)		,,CI	uci	18. Mother's Nar	ne (First, Middle,			LIOII
uld be	rked rice	To B	Sam Ferguson				Mart	ha		Fari	ris
2 sho	and r		19a. Informant's Name/Relationship (Type. Print)	19b. l	Mailing	Address (Street a	and Number or Ru	ural Route Numbe	er, City		
and	m 27 m 27 her tr		June E. Ferguson, wife			alton Roa					
ges 1	or ot		20a. Method of Disposition 1 □ Burial 2 🕅 Cremation 3 □ Removal from State			ition (Name of atory or other place		Date		ocation - City or	,
t. Pa	rtant:		4 □ Donation 5 □ Other (Specify)	Metropo		tan Crema				-	
berm	Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.	0	21. Signature of Funeral Service Licensee		22.	Name and Addres	10			al Home, Owings	P.A. MD 20736
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do no	t ente					OWINGS	Approximate Interval Between
Phy	sician		Immediate Cause (Final	CANCER							Onset and Death
	ledical		resulting in death)	a consequence of):						
Exa	aminer		Sequentially list conditions.								
pa	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):						
xecut	and Il-tran	xan		a consequence of	1:						
flicate be executed	physician and s the burial-transit				,,						
ificate	D 66	edical	d								
h cert		₹.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	pf pregnancy	۰۵	. 10 Unit				23d. Date of del	ivery
deat	e atte	icia	in the past 12 months?	2 Fetal death time of death		Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year
The law requires that the death cer	ed by the detached	Physician/N	9 ☐ Unknown 9 ☐ Unknown								
res th	igned be de	þ	Part II. Other significant conditions contributing to death b	ut not resulting in ti	he und	derlying cause give	n in Part I.				the cause of death?
requi	s been signed the should be det	ted					-	1 0	es 2	Pr No 3 Pr	obably 4 Unknown
we aw	has b	Completed						24a. Was autop	sy	prior to o	topsy findings available completion of cause of
	icate ha	S						perfo 1□ Yes	rmed? 2 X N	death? 1 ☐ Yes	2[X No
ician	certificate ector, paç	Be	25. Was case referred to medical examiner? 1♣ Yes 2 No Hospital: 1 Inpatie			Othe		ath (Check only o			
Phys	ral di	2	1		_	3[] DOA	4 ☐ Nursing H	T .		6 ☐Other (Spe	cify)
dlng	After	tion	1 ☐Natural 5 ☐ Pending (Month, Da			28c. Injury Work	es 2 □ No	28d. Describe h	iow iriju	iry occurred	
Atten	ector by the	fica	3 Suicide 6 Could not be determined 28e. Place of inju	ury - At home, farm	n, stree			28f. Location (S	Street a	nd Number or Ru	ıral Route Number,
talor	al Dir	Certification:	4 Homicide determined building, et	c. (Specity)				City or Tou	m, Stat	e)	
e Hospi		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/	death or inve	occurred at the timestigation, in my op	e, date and place pinion, death occu	e, and due to the urred at the time,	cause(s	s) and manner as ad place, and due	stated. to the cause(s)
To th	To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Da	ate signed (Monti	h, Day, Year)
. 1			Mullrenas	-M.D.		MD# 20) 459	A	UGU	ST 29, 2	007
8+1	X		30. Name and address of person who completed cause of d					14 OH ====			1500
	Sta	te		ar's Signature	TK,	VING STRE	ET NW,	<u>MASHINGT</u>	ON,	DC 20422	/688
4	Registra	_	AUG 3 0 2007 January 25.	Sporte	,						

			State of Maryland / Department of Heal 1 - State Registrar Certificate of Dec	ith and Me ath	ental Hygien		29724
			Decedent's Name (First, Middle, Last)	2	2. Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic		Anna Virginia Harden		09 1	2007	0330 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local	ation of Death	4	c. County of Deat	h
		ê	Frostburg Village Nursing Center Frostb			llegany	
	Funeral		Months Days Ho	Under 24 Hrs. 8 ours Min.	3. Date of Birth (Month, Day, Year	·) Co	hplace (State or Foreign untry)
	Director		212-01-9817		01 01 1	920 Mar	yland
vland	MOI.		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Mar	a-f si	ctor	MD Allegany Frostburg				YYes 2□No
ith the	or 28	Director	10e. Street and Number 10f. Zip Code			itizen of What Co	
ath w	3 23e	rai	18 Standish Street 21532			ted Sta	
er de	itam:	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Nover Married	nic Origin? (Speci lexican, Puerto Ri	ican, etc.)	14. Race - Ame Black, White	
ours aff	i', or	by F	3 ₩idowed 4 □ Divorced Year or Dates:	pecify:		Specify: Wh	ite
5 2	atura ical E	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	l na most of working	16b.	Kind of Business/	Industry
The V	Med.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during life. DO NOT use retired)	g most or working			_
N P	ygien t, the	Son	12 Housekeeping		First, Middle, Maide	<u>lospita</u>	1
	ad off	Be		,	iller Sl		
y y	d Mer marka maric	ို	Elijah Skidmore V 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N				Zip Code)
14 2 5 1	treur		Darrell Harden son 18 Standish S		Frostbu		
<u>ה</u> ה	if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28e-f show other treumatic avent, the Medical Exand actions to multiply at		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)	Da	te 20c. I	ocation - City or	Town, State
Pages	nt: if		1 Burial 2 Ix Cremation 3 Hemoval from State Cumberland Cremat	tory9-1	5-07 Cur	nberlan	d, MD
Definit. Pages			21. Signature of Funeral Service Licensee 22. Name and Address of	Facility 60 W	.Main S	t.Frost	burg, MD
a	2 2 2 3		Han Mowers moos47 Sowers Fun	eral Ho	ome P.A.		532
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)	ころうろう		Ce	mit /5 day
	'Medical xaminer		Due to (or as a consequence of):				
		ā	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
g bet	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
, exec	en an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):				
Of VICAL DECOLUS, F.C. DOX 60/80, P. Physician: The law requires that the death certificate be executed	physiclen and s the burial-transit	dical					
artifica	ing ph e as t		IF FEMALE:				
ath cer	attend for us	lan/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
. e	been signed by the attending p should be detachad for use as	Physiclan/Me	1 Yes 2 No 9 Unknown 9 Unknown				
that	deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did tobacco	use contribute to	the cause of death?
w requires t	n sign	d by	CONSESTIVE THEAT FAILURE		1 ☐ Yes	2□No 3□Pr	obably 4 Unknown
5 ĕ	s bee	olete	COKONARY MATERY BISERSE		24a. Was an	24b. Were au	itopsy findings available completion of cause of
That	te ha	Completed			autopsy performed?	death?	2□ No
cian:	rtifica ctor, p	Be C	25. Was case referred to medical examiner?	Place of Death /	(Check only one)		
Physic	his ce	오	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA		e 5 Residence		cify)
ing P	After t	iuoj:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?		d. Describe how inj	ury occurred	
Attending	death	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		3f. Location (Street a	and Number or Ri	ıral Route Number
0 A	Direction by	Certification;	4 Homicide determined determined building, etc. (Specify)		City or Town, Sta		
To the Hospital or Attending	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1SCertifying Physician: To the best of my knowledge, death occurred at the time, de (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinior				
the H	the F	Medical	one) and manner stated.			ate signed (Mont	
J _o	7 viti		29b. Signature and title of certifier 29c. License nur D 26 9			_	
					SEF	1EMB£	R 12,2007
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit S. S idhu MD 925 Bishop Walsh R	and Cur	nharland	MD 2	1502
-			31. Date filed (Month, Day, Year) SEP 17 2007 32. Tegistrar's Signature	Jau Cul	"OCT TAIL	, 110_2.	
	Sta	ite					

			For State Registrar	State o	f Marylan		artment of rtificate of			lental Hyg F	jiene eg. No 20 (7	29	725
			Decedent's Name (First, Middle	le, Last)						2. Date of Dea	th	•	3. Time o	
	Physici		Shao Ji Huan	a						Month August	27, 200	Year 7	8:15	M a
	/Medio		4a. Facility Name (If not institutio	<u> </u>	mber)		4b. City, Town,	or Location of			4c. County of		10110	<u> </u>
-	⊏Xallill	161	Shady Grove	Adventist	Hospita	- 1	Rockvil	le.			Moi	ı t.go	mery	
	Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs. i		If Under 1 Year	r If Under		8. Date of Birth	,	9. Birth	place (State	or Foreign
ы	Director		212-43-8804	1 3 M 2 □ F	73	Yrs.	Months Days	Hours	Min.	(Month, Day Dec. 23		Cou	ina	
			Usual Residence of Decedent								,			
	ylanc jow		10a. State 10b. County	,	10c. City	y, Town or Lo	cation						10d. Inside (City Limits
	Mar fied	to	Maryland Montq	omerv		Gaith	ersburg						1 ☐ Ye	s 2 √x No
	r 28a	irec	10e. Street and Number				10f. Zip Code				10g. Citizen of W	hat Cou	ntry?	
	3a o	<u> </u>	155 Lamont	Lane			2	0878			USA			
	ms 2	Funeral Director	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori	igin? (Spe	ecity Yes or No-	14. Race		can Indian,	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	/ Fui	1 ☐ Never Married 2 🔀 Mar	If Yes, Gi	2 No		ii Yes, specily Cu 1 □ Yes 2 ဩ No			nican, etc.)	Specify:	, White, Whi		
21215-0036	ural",	d by	3 Widowed 4 Divorced	Year or D										
5	"nat	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occu kind of work doni DO NOT use retin	e durina mos	t of worki	ing	16b. Kind of Bus	siness/in	austry	
12	withir sne.		Elementary/Secondary (0-12)	College (1-4or 5+)					.tation	Corross		.	
2	lled v lygie her t		17. Father's Name (First, Middle	/ act)		sec.	retary o	7			Goveri Maiden Surnam		τ	
Maryland	d be fental h	Be c	Lloyd Fu Ho	, 2031)				Luang			maidon barriam	-7		
\mathbf{Z}	shoul nd Me mark mati	မ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Stree				r, City or Town,	State, Zij	p Code)	
∑	nd 2 salth ar alth ar 27 is r trau	1	Rong Xin Wang/			15	5 Lamont	Lane,	Gai	.thersbu	rg, MD	2087	8	
Baltimore,	f Hear fem tem othe	F	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other pl	aca)	C	Date	20c. Location -	City or T	own, State	
no	ages ent ol rt: If i		1 ☐ Burial ※☑ Cremation 4 ☐ Donation 5 ☐ Other (State		itan Cre	· i	, -	2,				_
	artme ortan		21. Signature of Funeral Service				2. Name and Add		20	007	lexandr:	ia,	Virgi	ıia —
Ba	Depa impo any l		1 (unles)(10	0	į.							***	00001
	115		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the deat		OO Unive					orin	Approxima Interval B	
	1		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.		1	1 (- 1				Interval Be Onset and	etween J Death
	Physician /Medical		disease or condition resulting in death)	_a	conge	tre	nean	Tta	سائل	ul.			hour)
1	Examiner			Due to	(or as a consequent		sehem	~					/ ·-	D
		<u>.</u>	Sequentially list conditions,	b. Due to	Car du		SEVEN	di				-	hour	J
	ted isit	nin.	Sequentially list conditions, and y, cooling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	An one a second									
	and and Il-tra	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):						\dashv		
8760,	icate be executed physician and s the burial-transit	a												
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9 ×	ding se as	Me	IF FEMALE:	23c If yes ou	itcome pf pregna	ancv					23d. Date	of dolin	10D/	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2 ☐ Feta nant at time of d	al death 3[☐Ectopic pregnan☐Other (specify)				Mor		Day	Year
	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkr		iealii Ji								
P.0	w requires that the death certifit been signed by the attending p should be detached for use as	Completed by Physician/Me	Part II. Other significant condit	ions contributing to o	leath but not res	ulting in the u	nderlying cause g	jiven in Part I	ı,	23e. Did to	bacco use contr	ibute to	the cause of	death2
Records,	signe d be	l by	hyperte	Sim						1 🗆 ١	′es 2 No	3 ☐ Pro	bably 4	Unknown
Ö		stec	- An part								lan i			9.14
}ec	B 8 C	nple	-					· · · · · · · · · · · · · · · · · · ·		24a. Was	sy / p	vere aut rior to co leath?	opsy finding ompletion of	cause of
=	cate pag	ပ္ပ								1□ Yes		Yes	2□ No	
/ita	clan ertifii	Be	25. Was case referred to medic examiner?						e of Deat	h (Check only o	ne)			
2	hysl this c	မ	1 Yes 2 No		Inpatient 2		. 00 2011				lence 6 Othe		ify)	
L C	Attending Physician: r death. ector: After this certifica by the funeral director, I	ü	27. Manner of Death 1 Natural 5 ☐ Pendi	ng 28a. Date	of Injury hth, Day Year)	28b. Time o Injury	l W			28d. Describe I	now injury occurre	ed		
Sio	eath.	cati	2 Accident invest	igation				☐Yes 2☐						
Division or Vital	ter de lirect	Certification:		mined Zoe. Plac	e of injury - At ho ling, etc. <i>(Specif</i>	ome, farm, st fy)	reet, factory, offic	е		28f. Location (5 City or Tov	Street and Number vn, State)	er or Rui	rai Route Nu	ımber,
	ital (Ins af ral D	Cel												
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical		ing Physician: To the Examiner: On the	basis of examina									e(s)
	ithin 2 the mple	Med	29b. Signature and title of certifi	er	nner stated.		29c. Lice	nse number			29d. Date signed	(Month	, Day, Year)	
	F.≱ ₹ 8	-	h Asa	Single.	m 1)			5992	9				- 200	
	0			/		00.1.		2/11	1			ec +	700	7
	-		30. Name and address of person Aaron M. Snyd	er, M.D.	9901 N	Medica	l Center	Drive	, Ro	ckville	, MD 208	350		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year AUG 3 1	2007	Registrar's Signa	ature	anti s			-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. N2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 7, **Physician** Paul Henry Imphong 12:02P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Memorial Home Boonsboro Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1XM 2□F 230-14-4982 Director October 21,1912 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1X Yes 2 No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Maryland Avenue 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ՃYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or Item edical Examiner Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify: White þ 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natus any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington County Elementary/Secondary (0-12) College (1-4or 5+) 12 School Teacher Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ludwig Imphong Annie Elizabeth Lieberum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 73 Biddle Road Carlisle, PA 17013 se of Disposition (Name of Date 20c. Loc Thomas M. Imphong/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Paul's Lutheran 09/10/2007 | Hancock, MD re of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each type. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Examiner Sequentially list conditions, only along to immunica-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ng physician and as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown anemia 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Degeneralme arthrops 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

Division or Vital Records, P.O. Box 68760, ours after death.
neral Director: A within 24 hours a To the Funeral L

29b. Signature a tle of certifier

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAFAR MALIK, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-2222

State Registrar (Check only one)

Registrar's Signature

44996

State of Maryland / Department of Health and Mental Hygiene, 29727 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 2007 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JUI (V) Co dolder Frederick Frederick Center 5. Social Security Number If Under 1 Year If 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. Director 404-60-0448 90 August1,1917 Kentucky Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Jefferson Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code U.S.A Funerai 3916 Southview Court 21755 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 ☐ No Specify: Specify: White δ 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Hotel 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Loranzy Guest Stephen Alvie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 s ment of Health an Depertment of Health a Important: If item 27 Is any injury or other tra Dale L. Stevens P.O.Box 441, Jefferson, Maryland 21755

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, St. 20a. Method of Disposition 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State Lawn Cemetery 9-14-07 Erlanger, Kentucky 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Lipensee Marzullo Funeral Chapel, P. A. michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 6009 Harford Road Baltimore, Maryland21214 **Physician** Cerchrormaler accident Immediate Cause (Final disease or condition resulting in death) MONTHS /Medical Examiner Due to (or es_e consequence of): YKARS Demention Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed ed by the ettending physician end deteched for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): YCALS. Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? To the Funerel Director: After this certificate has been signed by vice properly filled in by the funeral director, page 2 should be detect 1 Tes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Uvrsing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident after death Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) D 006 2223 completed cause of deeth (Item 23a) (Type, Print)

LUM, MD 196 TJDLIVE FREDELICE, MD

32 Registrar's Signature . Name and address of person who PLAYEEN BOLARUY, MD State Registrar

07-06885 Yvette Anise Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29728

			1- For State			Certifi	cate of	Death			Reg	. No	
	hysicia		Registrar 1. Decedent's N	ame (First, Middle,Las	t)					2. D	ate of Death	Day Year	3. Time of Death 1545 hrs
	Examir		Yvett	e Anise	Jones						onth eptember	4, 2007	
				ne (if not institution, giv		r)	41		n, or Location of	f Death		4c. County of De Prince Geo	
			Southern	Maryland Hospi	tal Center			Clinton			- (Dist		. Birthplace (State or
F	uneral		5. Social Securi	ty Number 6. S	ex 7. #	Age (In yrs. last b	oirthday)	If Under 1 Months	Year If Under Days Hours	_		IFO	reign
D	irector		578-78	3-2236	M 2 X F		50_Yrs.	MOTUIS	Days	- Z	April	15,19 <u>5</u>	Pountry) Wash., DC
			Usual Resident										10d, Inside City Limits
	any		10a. State	10b. County		10c. City, Tov	wn or Location	on					1 X Yes 2 No
-	Mo al	_	Md.	PG		Oxo	n Hil	L1					
100	a-fs	유	10e. Street and	Number		- 		10f. Zip Co	de	3.0	10	g. Citizen of What (Country?
9	or 28	Director	6229	Oxon Hil	l Road	#301		20	745		Ţ	United S	States
4	23a noti	<u>=</u>	11. Marital Stat		12. Was Decede		13. Was	Decedent of	of Hispanic Orig	in? (Specif	y Yes or No-	14. Race - A White, et	merican Indian, Black,
	atn w	Funeral		larried 2 Marrie	Armed Force	es? 2 X No	If Ye	es, specify C	Cuban, Mexican;	; Puerto Rica	an, etc.)	vviille, ei	
	er de	교	3 Widowe	d 4 X Divorce	1 Yes d If Yes, Give Year	Z A NO	1	Yes 2 X	No specify:		- 11	Specify: B1	.ack
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36	e. than	ם			2			Secr	etary				n Md. Hosp.
8	d wit	Completed	17. Father's Na	ame (First, Middle, Las	t)				18.Mother	's Name (Fir	st, Middle, M	laiden Surname)	
15	e file tal H ked o nt, th	Be (Willi	e Lee Jo	nes				Vir	ginia	Me]	ton	
21215-0036	should be filed within 12 hours after death with the Mayyanu and Mantal Hygienes, and Martal Hygienes, 15 is market other than "natural", or items 23a or 28a-f sho I stin event, the Medical Examiner must be notified at once.	2	19a, Informant	's Name/Relationship	Type, Print)	(46)	19b. Mailing	Address	(Street and Nun	nber or Rura	Route Num	ber, City or Town,	State, Zip Code)
9	2 sho h and 27 is imati	'	Yvonn	e Brannu	m/siste		<u> Wash</u>	ingto	fut P	200	19"	20c. Location - Ci	ity or Tourn State
ر ک	l and 2 Health item 2'		20a. Method o			oro	ce of Dispos matory or oth	sition (Name her place)	of cemetery,	D	ate	20c. Location - G	Ly of Town, State
ŏ	Pages ient of int: If ir other		1 X Burial			State	nwood		etery	9/8/	07	Washing	gton, DC
Baltimore, MD	permit. Pages I and 2 should be filed within 72 hours arter ceain with the Manyauor operation of Health and Mental Hygiene. Begartinent of Health and Mental Hygiene. Inportant: I fitem 27 is marked other than "matural", or items 23a or 28a-f show. Injury or other traumatic event, the Medical Examiner must be notified at once.	ļ	4 Donation	on 5 Other Special Of Funeral Service Lice	ry: enspee ø					y Hodo	es &	Edwards	F.H.
Ba	permit. Departir Imports injury o	1	M	mma	Horlor		139	10 Si	ilver l	H1LL	Rd.,	Suitiar	na,Ma. <u>20746</u>
Ph	ysician	┢	23a. Part I. Er	ter the disease, or cor	nplications that cau	sed the death. D	o not enter t	he mode of	dying, such as-	cardiac or re	spiratory arr	est; shock, or heart	Approximate Interval Between Onset and
	Viedical			st only one cause on	_{a.} Hypertensive	Atheroscler	otic Card	iovascula	r Disease		<u> </u>		Death
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			Sequentially I	ist conditions.	b					este l	4		
		ner.	if any, leading	Underlying Cause	Due to (or as a o	collectivinge of):			No.	4			
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W.	cuted ind transit	l ä	events resulti	ng in death) Last	d.								
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P.O.	The law requires that the death certificate has been signed by the attending mase 2 should be detached for use as the	1		significant condition	ns contributing to	death but not res	sulting in the	underlying	cause given iii i	GIT II			Probably 4 🗸 Unknown
	ires the significant of the sign		<u> </u>						<u> </u>		24a. Was		/ere autopsy findings available
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Division	ospital or Attenchours after death	III Da	1 Natu 2 Accid 3 Suic 4 Horr	determ	not be						or Town,	State)	
_	E 0 5			1 Certifying Phy	sician: To the best	of my knowledg	e, death occ	urred at the	time, date and	place, and c	lue to the ca	use(s) and manner	as stated.
	the H in 24 the F	completely	(Check only one) 29b. Signatu	1	iner:On the basis o	f examination ar	nd/or investig	ation, in my	opinion, death	occurred at	the time, dat	e and place, and di	ue to the cause(s)
	To the I	Loo	29b. Signatu	re and title of certifier	and manner st	ated.			. License numb			29d. Date signe	ed (Month, Day, Year)
		1	D.	$ \cap$		PODA). 6.		O.C.M.E.			September	5, 2007
	ر		10	nd address of person v	en Ma	e of death (Item	23a)	-					
	5			nd address of person w a Aronica-Pollak		e or death (item ant Medical E	Examiner	111 P	enn Street,	Baltimore	e, MD 212	01	
			O4 Data file			gistrar's Signatu							
		Sta	(C) S I. Date file	d (Month, Day, Year)	- P		Don	and i					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrer 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Robert Lee Kabrick, Sr. September 11, 3:30 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4909 Old Middletown Road Jefferson Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 18, 1938 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 √ M 2 ☐ F Maryland 69 Yrs. 218-34-4061 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelih and Mental Hyjiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2X No Jefferson Frederick Directo Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21755 4909 Old Middletown Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces?

1 Ayes 2 1957-1961
If Yes, Give 1967-1961
Year or Dates: 1 Never Married 2 Married White 1□Yes 2ŽNo 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) US Postal Service Quality Assurance Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emily Louise Lenhart William Thomas Kabrick, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Harriett J. Kabrick, wife 4909 Old Middletown Road, Jefferson, MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Memorial Gardens Sept. 14, 2007 Frederick, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Keeney and Basford PA Funeral Home MOO255 106 East Church St., Frederick, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician monic /Medical Due to (or as a consequence of) Examiner Hyperterio Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as a consequence of) Examiner The law requires that the death certificate be executed sicien and burial-transi Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical e ettending physes IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Drabela Meelitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 2 No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: , In by the f 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours aft Funeral Di letely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely within 2 29d. Date signed (Month, Day, Year) September 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave derick, MD 21 2. Registrar's Sigpature Registrar

			For State Registrar	State	of Maryla		artment rtificate			nd Me	ntal Hy	giene	007	29730
Kif Mr.	80		negistrar Decedent's Name (First, Middle)	e, Last)			imeate	01 00	Catri	2	. Date of De		00,	3. Time of Death
F	hysici		George Wash	ington K	emn	Sr				١,	Month	29,	2007	
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			Solomon's Nu	rsing Ce	nter			Sol	omon	S			Cai	lvert
F	uneral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Months	Year I	f Under 24		. Date of Bir (Month, Da	rth av. Year)	9. Birtl	hplace (State or Foreign untry)
Di	rector		578-44-7841	1 ∑ M 2□F	71	Yrs.	THI OTHER		riodio		3/22/	1936	_	York
and	*		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
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d 2 sl	7 Is r traur												Town, State, Z	•
± an Feal	em 2		George W. Ke 20a. Method of Disposition	mp, Jr.	20b.	Place of Dispo	sition (Name	of	a Av	e.,			derick	
ages ent of	t: If it		1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		-			11 15	2007			,
mit. Pages partment of	Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		21. Signature of Funeral Service	***	CI	nes.Hi	S. Name and		of Facility					ic, MD
Dep de	any Ir		VC. U	1801			О Вох							, P.A.
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	edical		disease or condition resulting in death)	a. Due to	(or as a consec	quence of):	10	-470	,10 (vus	Cula	1600	2002	
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that	been signed by the attending I should be detached for use as		Part II. Other significant condition	ons contributing to d	eath but not res	sulting in the u	nderlying cau	se given i	in Part I.		23e. Did 1	tobacco us	se contribute to	the cause of death?
requires	n sigr Ild be	d by	Peripheral	Vascul	er d	iseas	2				12	Yes 2]No 3□Pro	obably 4 Unknown
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ysici	is cel direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2] ER/Outpatien	t 3 DOA						□Other (Spec	sify)
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or Att	irect ι by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of injury - At h ing, etc. (Speci	iome, farm, str	eet, factory,	office		281	. Location (. City or To	Street and wn, State)	Number or Ru	ral Route Number,
ital o	led ii													
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyir (Check only one) 2 Medicai	g Physician: To the Examiner: On the b	asis of examin	owledge, deatl ation and/or in	n occurred at vestigation, i	the time, n my opini	date and plion, death	place, an occurred	d due to the at the time,	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
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			30. Name and address of person	who completed servi	o of dooth //	m 23a) /T.m-				7	CHI		1	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Johns Social Security Number (In vrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) Months Hours 1 □ M 2 💢 F MARYLAND 54 213-66-8066 Usual Residence of Decedent 06/24/1953 10c. City, Town or Location 10b. County 10d. Inside City Limits INMOOD 1 ☐ Yes 2 No BERKELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25428 670 SULPHUR SPRINGS RD. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) VERIZON College (1-4or 5+) Elementary/Secondary (0-12) SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIARD BERNARD STOTLER DOLLY MAE VEST 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 670 SULPHUR SPRINGS RD., INWOOD, WV 25428 Jay E. LeDane / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/02/2007 SMITHSBURG CREMATORY SMITHSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821 21. Signature of Funeral Service Licensee Drown Marles M 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24 hours Due to or as a consequence of): Progressive Fibrosing Hepatitis Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Inpatient 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Dr ath 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

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To the Funeral C

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Physician

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Examiner

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Director

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Department of H Important: If ite any Injury or ot once,

Pages 1 and 2 should be

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Baltimore, Maryland 21215-0036

Director

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The law requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760. the ed by the attending properties of detached for use as certificate has b irector, page 2 s To the Hospital or Attending Physician: director

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MEDICAL DECTOR

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOPKINS HOSPITAL 600 NORTH WOURS STREET, BALTHORE MARMAND EARY JOHNS 31. Date filed (Month, Day, Year) SEP 1 7 2007 32 Registrar's Signature

n State

Registrar

			For State Registrar	State of Ma	ryland		rtment of tificate of			ntal Hyg	giene Reg. No 0	07	29732
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	/Medic		4a. Facility Name (If not institution, giv				4b. City, Town,	or Location of		AUGUST	4c. County	2007 of Death	7. 5
	LAdilli	iei	Shady Grove A		Host	oital		ckvil				rgomi	ERY
	Funeral Director		5. Social Security Number 6. S		(In yrs. las		If Under 1 Year Months Days	If Under	24 Hrs. 8	Date of Birth (Month, Day		9. Birthp	place (State or Foreign
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0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 The If Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cul ☐ Yes 2 X No			fy Yes or No- can, etc.)	14. Had Bla Specii	ce - Americ ck, White, by: C1	
5	72 hou natura lical E		15. Decedent's Education (Specify only highest gra	ducation	1	16a. Deced	ent's Usual Occu	pation	t of working		16b. Kind of B	usiness/In	dustry
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a S	shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Stree	t and Numbe	er or Rural F	Route Numbe	r, City or Town	, State, Zip	Code)
Ξ `	and 2 ealth in 27 I		Yuet Hing Ko	(Wife)			0skal	oosa	Driv	e, De	rwood,	, MD	20855
ב	ges 1 t of H If iter or oth		20a. Method of Dieposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cen	netery, crem	sition (Name of natory or other pla		Date		20c. Location	-	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier (Check only one) Certifying Ph	nysician: To the best of miner: On the basis of and manner state									
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otato of the		Cert	ificate of l	Death	F	leg. No2 (007	29733
×	Physici		1. Decedent's Name (First, Middle, L. Donald	Jame	es		Lyo	ns	2. Date of Dea		200 ′7 ªr	3. Time of Death 11:40p M
	/Medio Examin	11.00	4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death			inty of Death	de1
0	Funeral Director		5. Social Security Number 6. 391–46–9259		e (In yrs. last bir	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6/10/19	n v, Year)	9. Birth	place (State or Foreign ntry) COnsin
	Maryland a-f show ified at	ctor	Usual Residence of Decedent 10a. State	ınde1	10c. City, Town		ation					10d. Inside Cify Limits 1 ∐Yes 2 X No
	ith with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 1679 Walleye Di	ive			10f. Zip Code 2111			I	of What Cou JSA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent If Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba ☐ Yes X No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, ecify: W	
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Mary	and 2 shou alth and M 27 is mar er traumat		19a. Informant's Name/Relationship Ruth Susan Lyons			-		and Number or Ru Prive Cro		-	wn, State, Zij	p Code)
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68760,	law requires that the death certificate be executed as been signed by the attending physician and as been signed for use as the burial-transit and a second control of the secon	dical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. COVENA Due to (or as b. Due to (or as c. OULLD)	a consequence	of):	disease ut dial cular c	veter disease)			Interval Between Onset and Death
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	20e. Flace Of IIII	ury - At home, fa c. (Specify)	arm, stre	et, factory, office		28f. Location (3 City or Tou	Street and N vn, State)	umber or Ru	ral Route Number,
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4	3100		30. Name and address of person where RONALD C.		leath (Item 23a) M . D.	(Type, F	Y VILLA	00184 GE GRE	EN CR	OFTON	, MD	2114
	St: Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3 0	32. Pegistr	ar's Signature	A	-			1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 17 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAIER Day Yeer Month 3.50 PM Pultann **Physician** 72003 Siplem he) /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City Howard Ellicott City Rehab.&Conv.Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 M X F August12,1923West Va. Director 233-30-3037 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event, If a Madical Exacultment was be notified at 1 Tyes 2 No Windsor Mill Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21244 8606 Kratz Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ No Specify: Specify: White δ 3 X Widowed 4 □ Divorced leted 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Comple Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Pollock Charles W. France 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 271 Lesage, West Virginia 25537

20b. Place of Disposition (Name of cametery, crematory or other place)

Date 20c. Location - City or Town, State Fred W. Maier, Jr. 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Highland Cemetery 9/12/07 Huntington, West Vir. 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee 6009 Harford Road Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breant Carcinoma Metastalic Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in y leading to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) tuneral director. 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No ursing Home 5 Residence 6 Other (Specify) Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending nours after death.
nere! Director: At filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 [™] Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 7 2007

29b. Signature and title of certifier



E (1) and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1) 30641

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 29735 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) september 11,2007 **Physician** 8:00 a.M Blane Howard Miller, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Aberdeen 670 W. Bel Air Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 11/20/1951 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F Pennsylvania 55 Yrs. 220-54-8002 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County **ehow** me 23a or 28a-f ehov iXXves 2 No Aberdeen **Funeral Director** Harford MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21001 670 W. Bel Air Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Date Vietnam 14. Race - American Indian. ital Hygiene. Id other then "natural", or iteme: event, the Medical Examination 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Air craft Aircraft Refueler 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Iment of Health and Mental Blane H. Miller, Sr. Marquerite Steltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21001 Aberdeen, Maryland Department of Health ar Importent: if item 27 is only injury or other trau 670 W. Bel Air Ave. Arlene V. Miller (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 ☐ Removal from State 9/17/07 West Chester, PA R. A. Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility Tuneral Home, P.A. Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Datocell **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: / d in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Charles Rad, _ mD/LE9c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO06640 Assoc Prof. of Oncolor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1550 Or Lean Street 6+1 MOPLO Billy in 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		4	For State Registrar	State of Ma	aryland / De <i>C</i>	partment of F	lealth and N Death	Mental Hygie	200	17	29736
	#		Decedent's Name (First, Midd					2. Date of Death Month	Day Y	(021	3. Time of Death
ı	Physicia /Medic		Earl Evans	Mayfield,	Jr.			Septembe	er 12,	2007	7:15a ^M
	Examin		4a. Facility Name (If not institution	on, give street and number)		4b. City, Town, o	r Location of Death		4c. County of		
			322 North Earl		- /l lA bisbel		le Grace If Under 24 Hrs.	8. Date of Birth	Harfo		ce (State or Foreign
	Funeral Director		5. Social Security Number 234–68–7616	37	e (In yrs. last birthda 63 Yrs	Months Davs	Hours Min.	July 21,	ear)	Country	irginia
L.			Usual Residence of Decedent					Dury 217	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	nrylan show	_	10a. State 10b. County		10c. City, Town or					10d.	I. Inside City Limits 1 ☐ Yes 22No
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	with the party of		10e. Street and Number 322 North Ea	arlton Rd.		21078	3		U.S.A.	,	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent of H	tispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		- American White, etc	
õ	hours after death with the Maryland ture!; or Iteme 23a or 28a-f ehow al Erati ar must be notified at	Fu	1 Never Married 2 Ma	rried 1 ∐ Yes 2√02(1 ☐ Yes 2 🛣 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	Whit	
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<u> </u>		2	Earl Mayfiel		105.14	ailing Address (Street			ity or Town S	State Zin C	inde)
a Z	17		19a. Informant's Name/Relation Ellen Jean May		1	North Ear					1
<u>ة</u>	s 1 and 2 if Health Item 27 i		20a. Method of Disposition	, 1101a (Dpoud	20b. Place of Di	sposition (Name of crematory or other pla			c. Location - C		
Ê	0 0		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (3 □Removal from State SpecifyMausoleum	Harfor	d Memorial	Gardens	9/14/07Ab	erdeen	, Mar	yland
<u>=</u>	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service		- , ,	22. Name and Addre Tarring-(Aberdeen,	ess of Facility	eral Home	. P.A.		
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	thet the death cert ed by the attendin detached for use	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant a		5 Other (specify)			Mon	ih D	ay Year
о. О.	d by It	Phy	9 ☐ Unknown Part II. Other significant condi		out not resulting in th	e underlying cause ar	ven in Part I	23e. Did toba	cco use contri	bute to the	cause of death?
ds,	ires the signed d be de	ρ	Part II. Other significant condi	tions contributing to death t	our nor resulting in th	e underlying cause g.	VOIT WIT CARE			3 🗌 Probab	
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Bě	ne tav e nas age 2	Completed						autopsy performe	ad? de	rior to comp eath? □ Yes 2	pletion of cause of
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Sio	tendi death. tor: A	ertification;	2 Accident inves	d not be 280 Place of in	iun - Al home Jarm]Yes 2□No	28I. Location (Stre	et and Numbe	or Or Rural	Route Number.
Division of Vital Records,	l or Attendate death of the office of the of	ertif	4 Homicide deter	mined building, e	tc. (Specify)	, street, lactory, office		City or Town,			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	caic	29a. Certifier Certify (Check only 2 Medical	ring Physician: To the best	of my knowledge, of	eath occurred at the t	ime, date and place	a, and due to the cau	use(s) and man	nner as star	ted.
	the H in 24 the Fi	Medical	one)	and manner s			se number		d. Date signed		
	5 1 × 5		29b. Signature and title of certification	1 Shear	Talas 11	250. 2.00	14700	7	9/1	2/15	7
	le		30. Name and address of person	on who completed cause of	death (Item 23a) (Ty	rpe, Print)	We sta	16 Mil.	2107	/ / //	
	-	ate	31. Date liled (Month, Day, Yea	ar) 32 Regisl	rar's Signature	pe, Print) 2 UN PAU DECEMBER	91.00	Jan J			
	Regist		SEP I	7 2007 Jac	ind Sis for	J. D. B. P. C. C. C. C. C. C. C. C. C. C. C. C. C.					

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State of Marvland / Department of Health and Mental Hygien 7 0 7

		ľ	1 - For State Registrar	State of Ma		ertificate of l			ENO.	29131
	01		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic			rcella	Marsoli	С		Septembe	r 10 2007	
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)			Location of Death		4c. County of Deat	
			Somerford House 5. Social Security Number 6. Sex	7 400	(In yrs. last birthday		ederick If Under 24 Hrs.	8. Date of Birth	Frede	
	Funeral Director			M 2 🛪 F	95 Yrs.	Months Days	Hours Min.	(Month, Day,)	1911 Penr	hplace (State or Foreign buntry) ISYlvania
	/land		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Many	ţō	Maryland Freder	ick		Frederick				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
	ath wi		2100 Whittier Dr.	, #107			1702		U.S.	Α.
	teme teme	Funeral		Was Decedent Example Forces?	ver in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ane. then "naturel", or iteme 23s or 28s-f ehow the Medical Exercifier must be notified at	by Fi	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
8	2 hou	ed	15. Decedent's Educ	ation	16a. Dec	edent's Usual Occupa	ation	16	6b. Kind of Business/	
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nd	be filed ital Hygir of other event, I	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
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Maryland 21215-0036	d 2 st th and 7 is r treur	i i	19a. Informant's Name/Relationship (Type Elizabeth Poska/ d	•	10	ing Address (Street a			City or Town, State, 2	
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Baltimore,	글 본런 글 .		21. Signature of Funeral Service License	V/ 40	7	22. Name and Addres	ss of Facility Ha	rtzler Fu	uneral Hom	ne
Õ	Dapa Impo eny i		(atharine ().)	Jarker		11802 Libe	erty Rd.		town, MD	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to cause on each line	he death. Do not e	nter the mode of dyin-	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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39	ertifica ling ph		IF FEMALE:	# Ta 15000			_			
B 0	attend for us	Iclan/N	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome o	Fetal death 3	□Ectopic pregnancy			23d. Date of del Month	livery Day Year
Vital Records, P.O. Box	s that the death certined by the attending	yslo	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4☐Pregnant at ti 9☐Unknown	me or ueath 5	Other (specify)				
۵.	s thet	by Phys	Part II. Other significant conditions cont	ributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did toba	scco use contribute to	the cause of death?
rds	w requires to been signer should be contact.							1 ☐ Yes	2 X No 3 □ Pr	robably 4 □Unknown
ဝင္	e law re hes bec je 2 sho	plet						24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
œ —	ysician: The is certificate he director, page	Completed						perform	ed? death? No 1 ☐ Yes	
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Division of	ding h. After funer	tlon	1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Worl	yat k? Yes 2 □ No	280. Describe now	rinjury occurred	
<u> ISİ</u>	Attender deat	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm, s	street, factory, office	183 2 0.10	28f. Location (Stre	et and Number or Ri	ural Route Number,
á	s after	Certification:	4 Homicide	building, etc.	(Specify)	•		City or Town,	State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Madical Examin	ician: To the best of ar: On the basis of e and manner state	examination and/or	ath occurred at the tin investigation, in my of	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the I within 2 To the I complet	¥	29b. Signature and title of certifier	4		29c. License			d. Date signed (Mont	
}			Verl Waran	N n	1>	De	17611	S	Krt 11, 20	400
	5		30. Name and address of person who con			a, Print) Ney Ave.	F027	Frenzuck	C, MD 2	1702
	Sta Registr		31. Date filed (Month, Day, Year) SFP 1 7 2007	32. Registrar	's Signature	all of				

		•	For State Registrar		Cei	rtificate of	Death	B	eg. N2 0 0 7	29738
Maria Ta			Decedent's Name (First, Middle, Last	>t)				2. Date of Deat	h	3. Time of Death
	Physici: Medic/		Alemayehu N	lihret				Month August	29 2007	2:22 P M
	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of De	
#1.55 # 2 (E)			Holy Cross Hos 5. Social Security Number 6. S	*	yrs. last birthday)	Silver if Under 1 Year	Spring If Under 24 Hrs.	9 Date of Birth	Montgome	ery lirthplace (State or Foreign
	uneral irector			DXM 2□F	39 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 25	Year) 1968 Ac	Country) idis Ethiopia
aryland	show	_	10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits
he M	28a-f	Director		George's (College				0.000	
with	a or i	흡	10e. Street and Number 9010 St. Andres	ы Р1		10f. Zip Code 20740			Og. Citizen of What of Africa	Country?
death	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto		14. Race - Ar	nerican Indian,
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٦	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		_	an', Mexican', Puerto Specify:	Rican, etc.)	Black, WI	nite, etc. hiopian
2 PG	ical E	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	oation		16b. Kind of Busines	ss/Industry
Maryland 21215-0036 nd 2 should be filed within 72 hours af lith and Mental Hygiene.	an "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worki d)	ig		
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Md 2 salth ar	27 is r trau		Elelta M. Agonafe:	•					ark, Md.	•
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mo Page	int: If	ы	XXBurial 2 □Cremation 3X 4 □Donation 5 □ Other (Specifi	Removal from State	Addis A			5,2007	Ethiopia	
Baltimore, permit. Pages 1 an Department of Hea	Importa any Inju once.		21. Signatur of Funeral Service Cen							eral Home Inc D.C. 20020
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State of Maryland / Department of Health and Mental Hygien 2007 29739 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 29, 2007 2007 **Physician** RICHARD REPP 22:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON NMS HEALTHCARE OF HAGERSTOWN HAGERSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Y 6/8/1922 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1**X**XM 2□ F MARYLAND Yrs. 85 Director 212-14-6980 Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Mcdical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director WASHINGTON HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 13938 SUNRISE DRIVE 21740 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "natural; or ite njury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo WHITE Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cottege (1-4or 5+) Elementary/Secondary (0-12) MACK TRUCK 12 MACHINIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) RUSSELL R. REPP RUTH FORSYTHE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8608 SHERINGTON ROAD, NOTTINGHAM, MD 21236 THERESA FERRIS/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition SEPTEMBER 1 Burial 2 □ Cremation 3 □ Removal from State 1, 2007 ROSEDALE CEMETERY MARTINSBURG, WV 4 Donation 5 Other (Specify) permit.
Deportmit.
Importe any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 1 com 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Priysician Chron very. /Medical Due to (or as a consequence of): **Examiner** ementia Sequentially list conditions, if any, bearing to himselfate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner One to for as a nonsequence of) sician and burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XXnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of tnjury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 St. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 09-04-2007 052323 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1126 OPAL CT., HAGERSTOWN, MD 21740 KHALID WASEEM, M.D., 31. Date filed (Month) 32. Registrar's Signature 2007 Anales 1 State Registrar

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State of Maryland	/ Department of Health and Mental Hygien 2007	29/4	, 1

"natural" or items 23a or 28a-f ahow Daniel Examinar must be notified at the profile of the prof	1. Decedent's Name (First, Middle, Interpretation of the Communication) GERALDINE G 4a. Facility Name (If not institution, of 17 Old Hilltop) 5. Social Security Number 220-40-9848 Usual Residence of Decedent 10a. State 10b. County MD Cecil 10e. Street and Number 17 Old Hilltop Interpretation 17 Old Hilltop Interpretation 18 Never Married 2 Married 3 Widowed 4 Divorced	SIZEMORE pive street and number) Road Sex 1	yrs. y, Town or Loc Conowi	ngo 10f. Zip Code	_	2. Date of De. Month Septem h 8. Date of Bin (Month, Da 3/7/19	Day Year ber 8, 20 4c. County of Di Ceci	007 9:00A M
Funeral Director	4a. Facility Name (If not institution, g. 17 Old Hilltop 5. Social Security Number 6 220-40-9848 Usual Residence of Decedent 10a. State 10b. County MD Cecil 10e. Street and Number 17 Old Hilltop I 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Road Sex 7. Age (In yrs.) 1 M 20 F 63 10c. City 12. Was Decedent Ever in U. Armed Forces? 1 Yes, Give Year or Dates:	yrs. y, Town or Loc Conowi	If Under 1 Year Months Days ation 10f. Zip Code 21 As Decedent of H	ingo If Under 24 Hrs Hours Min	8. Date of Bird (Month, Da 3/7/19	4c. County of Di Ceci b, Year)	eath 1 Birtholace (State or Foreign Country) Maryland 10d. Inside City Limits
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0 P 4	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k	ent's Usual Occup- tind of work done of O NOT use retired	during most of wo ()	rking	16b. Kind of Busine	•
and Mentel Hygiene is marked other than aumait: event, the M To Be Comp	17. Father's Name (First, Middle, La William Walte	,			18. Mother's Na	me (First, Middle, ne Jane	Maiden Sumame) Scott	· · · · · · · · · · · · · · · · · · ·
The state of the s	19a. Informant's Name/Relationship Roger Brewer, J1 20a. Method of Disposition 1 ☑ Buriai 2 □ Cremation 3	C./Son 20b. P	17 (Place of Dispos	Old Hill	top Road		ngo, MD 2 20c. Location - City Darlingto	21918 or Town, State
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To the within 2 To the complei	29b. Signature and title of certifier	S		29c. Licenso	0564	49	29d. Date signed (Mo	onth, Day, Year)
State		no completed cause of death (Item Som MD 111 32 Registrar's Signa	Wes-	High High	St.Su	ite 3	02 EIKt	87 MD 2193

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien \circ \circ \circ \circ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 05A /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 5916 Old Solomns Island Road Tracys Landing Anne Arundel 8. Date of Birth (Month, Day, Year) 11/10/1932 Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) If Unae Hours **Funeral** Months Days 1 □ M 2 1 F 577-42-9155 Director 74 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Anne Arundel Tracys Landing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20779 5916 Old Solomns Island Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Human Resource Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၀ John Vast Betsy Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20779 19a. Informant's Name/Relationship (Type. Print) Leroy Seipp/Husband 5916 Old Solomns Island Road, Tracys Landing MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 08/30/2007 Cheltenham, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral S 8125 Southern Maryland Blvd., Owings MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ADENO CARCINOMA Physician /Medical Due to (or as a consequence of). Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Tyes 2 🗌 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 🗌 Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 Other (Specify) 27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury (Month, Day Year) Natural thours after death.

uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af **To the Funeral D**completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of or 29d. Date signed (Month, Day, Year)

01 Was

State Registrar ONCOLOGY CANTOR, 9 DUBESTE ATE ROAD, SULTE 300 ANNAPOLLS, MD 21401

	•	For State Registrar	Stat			i / Depa		ealth and	Mental Hyg	-	
Physicia	ın	Decedent's Name (First, Middle							2. Date of Dear Month	th Day Ye	3. Time of Death
/Medic		Margaret Wil 4a. Facility Name (If not institution					4b. City, Town, or	Location of Dea		27, 2007 4c. County of I	257. 3.60 M
		116 E. Bay Vie					Annapo			Ann	e Arundel
Funeral Director	9	5. Social Security Number 216-14-7507 Usual Residence of Decedent	6. Sex 1 □ M 2 □		(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		19 9.	Birthplace (State or Foreign Country) laryland
yland how at		10a. State 10b. County			10c. City,	Town or Lo	cation				10d. Inside City Limits
ne Mar 8a-f sl otified	Funeral Director	Maryland				Balti					1 AYes 2 No
with th	Ö	10e. Street and Number 3900 N. Charle	s Stroo	+ An+	311	1	10f. Zip Code 21218		1	og. Citizen of Wha US	•
death ms 23	nera	11. Marital Status	12 Was	Decedent Ev				spanic Origin?	Specify Yes or No- erto Rican, etc.)	14. Race - /	American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 【X] Widowed 4 ☐ Divorced	ied 1 If Ye	ed Forces? Yes 2 🕅 No s, Give or Dates:	0	1	f Yes, specify Cuba I □ Yes 2X No	Specify:	епо нісап, етс.)	Specify:	White, etc. White
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nd 2 sh lth and 27 Is n traun		19a. Informant's Name/Relations Constance N. S		*	or				Rural Route Numbel e, Annapol		
of Hear item		20a. Method of Disposition			20b. Pla	ce of Dispo	sition (Name of natory or other place	i		20c. Location - City	
Page ment cant: ant: if		1 🏋 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		from State	1	don Pa	rk Cemet	ery 8-3		Baltimor	
permit. Depart Import any inj		21. Signature of Puperal Service	Licensee			I .	Name and Address Name Solom		George P. and Rd. Ed		neral Home MD 21037
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause	that caused to on each line of the office of	aru	art	er the mode of dyin		ac or respiratory arr	est,	Approximate Interval Between Onset and Death
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Exist uncarriage Cause (Disease or injury that imitated events resulting in death) Last	b c d	ue to (or as a	conseque	,	1				220yrs
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1	s, outcome p Live birth 2 Pregnant at t Unknown	□ Fetal o	death 3	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Year
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he law recent has bee age 2 shou	Completed by	with sacem	alter 1	rylon	ted	8/1/	06, vas	cular	24a. Was a autops	sy prio med? dea	re autopsy findings available r to completion of cause of th?
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l or Al after d Direc	ertifi	4 ☐ Homicide determ	inod 200.	Place of injur building, etc.	y - At norr . (Specify)	ne, rarm, str	eet, factory, office		City or Tow		or Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	edical Co		Examiner: On		examination				ice, and due to the occurred at the time, o		er as stated.
To the within compl	Me	29b. Signature and title of certifie		1.			29c. Licens	e number	. 2	9d. Date signed (A	Month, Day, Year)
Les		nurej	HRO	ME 1	MO		104	1429	0	2+ A09	UST 2007
るから		30. Name and address of person Timothy L. Kro						200 I	utherville	MD 210	03
Sta	te	31. Date filed (Month, Day, Year)		32. Registrar	r's Sign <i>a</i> tu	ıre		200, LI	TCIIGI ATTT	=, rm 210	7.3
Registra	ar	AUG 3	U 2007	May		# 1	harte				

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato of mar	ylaria	-	tificate of		ana mo	R	eg. No.	007	29	43
	Physicia	an	1. Decedent's Name (First, Middle, Las Samuel E. Srou							Month	h Day	Year	3. Time of	Death A M
	/Medic	al	4a. Facility Name (If not institution, give				4b. City, Town,	or Location		ugust	29 4c. C	2007 county of Death	3:40	AW
	Examin	er	Anne Arundel Medi					Ann	apolis			Anne A		
	Funeral Director		200-10-0100	ex 7. Age (▼ M 2 F	In yrs. lasi 84	t birthday) Yrs.	If Under 1 Yea Months Days		Min.	Date of Birth (Month, Day, ec. 5,	^{Yea} r) 192	9. Birthp Cour F1	lace (State ontry) orida	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, T	Town or Lo						1	0d, Inside C	ity Limits
	e Mary	ctor	Maryland Anne Ar	undel			Pasade	ena						2 X No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 869 B Swift Road				10f. Zip Code 21	122		1		en of What Cour	ntry?	
	er dea Items ner mu	uner	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. \	Was Decedent of f Yes, specify Cu	Hispanic Or ban, Mexica	igin? (Specify n, Puerto Ric	y Yes or No- an, etc.)	14	 Race - Americ Black, White, 		
0000	urs aft al", or Exami	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	943-	45	1□Yes 2XINo	Specify:			S	Specify:	White	
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7	within ene. than '	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	1		acturers					Sales		
alla z	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show attic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last) Elie Schlomo Sr							irst, Middle, i				
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	То	19a. Informant's Name/Relationship (Teg Srour/son	Type. Print)			ng Address (Stree			Route Number			Code) 228	
e,	of Hea		20a. Method of Disposition	Damoval from State	20b. Plac	ce of Dispo	sition (Name of matory or other pi	ace)	Date	Э	20c. Loca	ation - City or To	own, State	
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D	permit Depar Impor any In once.		21. Signature of Funeral Service Licer	see Zill	μ ω		2. Name and Add 7 Duke o			_				1401
Ĭ	9		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death.	Do not ent	er the mode of d	ying, such as	s cardiac or re	espiratory arr	est,		Approxima Interval Be Onset and	tween
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VIII	ding Physician: The lav. After this certificate has funeral director, page 2.		25. Was case referred to medical					OS Plan	o of Dooth //		2 01 No	1 ☐ Yes	2□ No	
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ISION	al or Attending safter death. Il Director: Afte d in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be		v - At hom	e, farm, str		Yes 2		f. Location (S	treet and	Number or Rur	al Route Nui	mber,
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(2 Open		30. Name and address of person who Dr. Douglas Mitch				Print) Parkway	Annap	olis,	Maryla	nd	21401		
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DU	Registi	20	AUG 3 0 2	2007	2	J. 1	fred							

			State of Maryland / Department of Healt State Certificate of Dea		ental Hygie	711111	29744
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	/Medic	al	Dorothy Roslyn Trice			0 2007	3:00 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat			4c. County of Deat	
	Funeral		1 3 3 4 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		8. Date of Birth	Talbe 9. Birt	hplace (State or Foreign
	Director		19/.14.5835 82 Yrs.	ours Min.	8. Date of Birth (Month, Day, Ye Oct. 28,	1924 Pen	nsylvania
	w w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
	Maryli fed a	io	Maryland Talbot Trappe				1 ☐ Yes 2 ☑ 1√0
	r 28a	irec	10e. Street and Number 10f. Zip Code		10g.	. Citizen of What Co	untry?
	ath with the Marylar 23e or 28e-f show	Funeral Director	5621 Marlan Drive 21673			USA	
	er dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	ic Origin? (Spec exican, Puerto A	cify Yes or No- tican, etc.)	14. Race - Ame Black, White	
336	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Spe	ecify:		Specify:	White
2-0	ilied within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ehow the Mazikal Examinar must be notified a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during	mast of workin	168	b. Kind of Business/	
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Z S	filed v Hygie other t	e Co	12 Manager 17. Father's Name (First, Middle, Last) 18. M	Mother's Name	(First, Middle, Mai	Shoe	
Tri	e d a b	To Be		ra Olia	•	don domaine)	
y ary	2 shou and M is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No.			ity or Town, State, 2	(ip Code)
othy re, Ma	iges 1 and 2 should nt of Health and Mer it I tem 27 ts marke or other treumatic		Walter F. Trice, Jr./Son 5621 Marlan Dr.,			673	
Dorothy Trice altimore, Maryland 21215-0036	Pages 1 nent of H nnt: If Ita nry or oti		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State	Da		c. Location - City or	
ŏ ₹	permit. Pag Department Importent: I any njury o	. 1	4 Donation 5 Dotter (Specify) Dorchester Mem. Park 21 Signature of Funeral Service Licensee 2 38, Name and Address of F				MD
Ba	Dep of the part of		2 Signature of Funeral Service Licensee 28 Name and Appress of Funeral Drontwo	eII fun Cambr	eral Hom	e, P.A. 21613	
			23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.				Approximate Interval Between
اه	Physician		Immediate Cause (Final disease or condition a. Cardiony of all y				Months
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ō	law requir es been si 2 should	ojete	Osteoprosis		24a. Was an	24b. Were au	topsy findings available
Re		Completed	Deterallistic		autopsy performed	death?	completion of cause of
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Division of Vital Records, P.O.	r Atter	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	Bf. Location (Stree City or Town, S	at and Number or Ru	ral Route Number,
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	To the Hospitel or Attending Physician: within 24 hours after deals after this certificator. After this certification the Funerel Director. After the completely filled in by the funeral director, to	edicai	29a. Certifier Clinic to the pass of my knowledge, death occurred at the time, date	te and place, ar , death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
4	To the within To the comple	Mec	29b. Signature and title of certifier 29c. License numb	ber	29d.	Date signed (Montl	n, Day, Year)
			DZ	5933		9.10.	DF
	4		30. Name and address of person who complete cause of death (Item 23a) (Type, Print) MICHAIL CROWLEY MD GIO DUTCHMAN	'o In	VIF		15 21601
	Sta	te	31. Date filed (Month, Day, Year) 2007 32 Registrar's Signature	> hith	الت الما	13/0N 1	וטמוא ניי
	Registra		SEP 1 1 2001 Marian 10 Marian				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2007 29745

Description of the property of		1- For State	Certific	cate of Death	Reg. I	
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Anne Groren's White etc. Whi	he Ma or 28	[] 6432 Neddlel	eaf Drive	20852		U.S.A.
Section Color Co	with t		12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin	n? (Specify Yes or No-	
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			State of Maryland / Department State of Maryland / Department Certificate Certificate			jiene eg. No. 2 A A 7	2071.6
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н	Physicia		William Arthur Thomas		Month Augus	t 28, 2007	10:51 P M
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	th with 23a or 1st be n	al Dir	3705 Ralph Road	20906		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 Married 1 Married 2 No	lent of Hispanic Origin? (Sp offy Cuban, Mexican, Puerto 2 ⊠ No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
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Maryland	lid be lental ked o	To Be	David Arthur Thomas	Bessie	Jane Br	ewington	
ary	shou and M s mai		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address	(Street and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)
	and 2			oh Road, Whea	aton, Ma	ryland 2090	06
ore	es 1 a of He filter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nam cemetery, crematory or of	ne of ther place) Set	Date ot. 4,	20c. Location - City or	
<u>Ĕ</u>	Page nent ant: II		4 Donation 5 Other (Specify) Gate of Heaven	i ('Amataru -	007	Silver Spr:	ing, Maryland
Baltimore,	permit. Departr Importa any inji			d Address of Facility S J. Collins Lversity Blvo			,MD 20901
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ñ	Examiner		Sequentially list conditions b. Respiratory Distress				2 Years
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P.O. Box	atten for u	Physician/M	in the past 12 months?			Month	Day Year
Ö	that the de led by the a detached f	ıysi	1 Yes 2 No 9 Unknown				
	Attending Physician: The law requires that the death certifur death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying or	ause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	quires n signe	d by			1 □ Y	es 2□No 3□P	robably 4 💆 Unknown
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8	sician: The law s certificate has I irector, page 2 s	шc			autop perfor	med? death?	completion of cause of 2 □ No
ta	an: tificat tor, p	Be C	25. Was case referred to medical	26. Place of Des	1 Yes ath (Check only or	2⊠No 1 □Yes	2 110
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0	g Ph ter th neral	ä	27. Manner of Death 28a. Date of Injury 28b. Time of 1 Natural 5 Dending (Month, Day Year) Injury	8c. Injury at Work?		ow injury occurred	
Ö	ath. Pr: Af	atio	2 ☐ Accident investigation M	1 ☐ Yes 2 ☐ No			
Division or Vital	al or Atte	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory building, etc. (Specify)	, office	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred to the past of examination and/or investigation, and manner stated.				
	To th withir To th comp	Me	29b. Signature and title of certifier 29c	c. License number	1	29d. Date signed (Mon	th, Day, Year)
	111		Monda Cotos D.O	H4643X		Aug. 3	1007
	111		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			J	,
_			Mindi E. Cohen, M.D. 15825 Shady Grove F	Rockvi	lle, MD	20850	
	Sta Registr		31. Date filed (Month Day Sar) 2007 32. gistrar's Signature	,			

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Ce	rtificate of Death	Re	2007	29748
	Physici		1. Decedent's Name (First, Middle, Last) Lawrence Kieffer Warn	nan, Jr	?•	2. Date of Death Month August	25, 2007	3. Time of Death 1329 M
)	/Medio		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Ce	enter	4b. City, Town, or Location of Deat Clinton		4c. County of Death	
	Funeral Director		5. Social Security Number 5. Social Security Number 5. Social Security Number 1 № M 2□ F 6. Sex 6. Sex 6. Sex 6. Sex 7. Age (In yrs.	last birthday)			Year) 9. Birth	place (State or Foreign
d Z IZ IS-UU30 filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notifiled at		Director		ty, Town or Lo	farlboro	10	g. Citizen of What Cou	10d. Inside City Limits 1 Mayes 2 □ No
death with	tial Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Di	14011 Rectory Lane 11. Marital Status 12. Was Decedent Ever in U	l.S. 13.	20772 Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer		USA 14. Race - Ameri Black, White,	can Indian,
-UUSO	itural", or it	by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
Baltimore, Maryland Z1Z15-0036 Bernit Pages 1 and 8 should be fled within 72 hours at	giene. er than "na the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	(Give	kind of work done during most of wo DO NOT use retired) Network Engine	rking	P.G. School	·
aryland should be file	Mental Hygi arked other atic event, t	To Be (17. Father's Name (First, Middle, Last) Lawrence Kieffer Warman, S		France		Wo	
s, Mar	1 00 -00 60	9	19a. Informant's Name/Relationship (Type. Print) Patricia Warman (wife)	1401	ng Address (Street and Number or R 1 Rectory Lane [Jpper Marl	boro, MD	20772
TIMORE 1	tment of H tant: If ite		4 □ Donation 5 □ Other (Specify) Re	surrec	tion Cem.	ıg 31 2007	Oc. Location - City or To	ח
Dall	Department Important; If any injury o		21. Signature of Poheral Service Licensee Gazy J. Roff	8	2. Name and Address of Facility ${ m Le}$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$	land Blvd	. Owings,	MD 20736
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r.C. DOA	been signed by the attendishould be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fets 4 ☐ Pregnant at time of continuous 1 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
Cours that	en signed b	by	Part II. Other significant conditions contributing to death but not res	sulting in the u	inderlying cause given in Part I.		acco use contribute to t	
		Completed				24a. Was an autopsy parform 122 Yes 2	24b. Were auto prior to co death?	opsy findings available impletion of cause of
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LIVISION OF	after death. Director: After this certifice I in by the funeral director, I	ation: To	27. Manner of Death 1	ER/Outpatier 28b. Time o Injury	A Nursing P	dome 5 ☐ Residen 28d. Describe how	ice 6 □Other (Speci. v injury occurred	fy)
ital or Affe	irs after de ral Directo lled in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury · At h building, etc. (Speci.	fy)		City or Town,	·	
he Hosp	within 24 hours after To the Funeral Dire completely filled in the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known one control of the basis of examiner on the basis of examiner and manner stated.	ation and/or in	nvestigation, in my opinion, death occ	urred at the time, da	te and place, and due t	o the cause(s)
To	vith To t	Σ	29b. Signature and title of certifier Amil Mahagin ml		29c. License number	290	d. Date signed (Month,	Day, Year)
W	ad		29b. Signature and title of certifier And C Manager MD 30. Name and address of person who completed cause of death (Iter 7501 Support	m 23a) (Type,	Print) ANILIC M UN OND 20735	MAASAN	MD. 5047	USPITAL.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month8/26/2007 Carl S. Ward Jr. 10:22am 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Millersville 1598 Millersville Rd. Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/26/1933 9. Birthplace (State or Foreign 1**%** M 2 □ F 74 216-30-1576 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Anne Arundel Millersville 1 ☐ Yes 2K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1598 Millersville Rd. 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 12 Yes 2 No 1953— If Yes, Give Year or Dates: 1955 1 Never Married Married Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl S. Ward Sr. Isabelle Stallings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1598 Millersville Rd. Millersville, MD 21108 Wife Margaret Eleanore Ward 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem 8/31/2007 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 FOSSISWEI AUZER Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was a autopsy performed? Ves 212 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

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Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve

72 hours after

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Pages .

permit.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

certificate be executed burial-Box 68760. physician Ö the by Division or Vital Records, P. The law requires

Examine Physician/Medical the attending for use as þ Completed certificate has page 2 director Be 70 Hospital or Attending

1 ☐ Yes

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

No

5 Pending investigation

6 Could not be

Certification: To the Funeral Director: completely filled in by the hours a Medical 24 To the

> State Registrar

29b. Signature and title of certifier

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

29c. License number 1) (636.4

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person w 40 E RU 300 AMMAPORIS MAD 21401

3□ DOA

28c. Injury at Work?

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Box 68760, P.O. Division or Vital Records,

Maryland 21215-0036

Baltimore,

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After filled in by

Medical completely State Registrar

31. Date filed (Month, Day, Year) 1

VASANT

29b. Signature and title of certifier

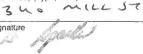
DOT MO

29a. Certifier (Check only one)

> DATTA MD 32. Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 18015

29d. Date signed (Month, Day, Year)

SEPT 10, 200)

MACERSTOWN, MD 21740

07-07030

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Allen State of Maryland / Department of Health and Mental Hygiene 2007 29751 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day September 10, 2007 0000 hrs **Medical Examiner** Charles Allen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1520 North Avenue Apt #308 **Baltimore** 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. **Funeral** 7. Age (In vrs. last birthday) Hours Director 214**-**26**-**1828 1XM 2 F 2-11-1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f shov MD n/a Baltimore notified at once, Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1520 W. North Avenue # 308 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Married African-American 4 X Divorced If Yes, Give Year Yes 2 X No specify: Specify: Examiner ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4 or 5+) tem 27 is marked other than traumatic event, the Medical 21215-0036 9th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Anthony Allen Maggie Hatcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ω Shirley Wells/Cousin 3202 Southgreen Rd., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 XX Cremation 3 Baltimore, MD Metro Cranatory Conation 5 Other Specify 22. Name and Address of Facility Wylie F/ H P.A. of Baltimore County ature of Fyn. ral Service Licens 9200 Liberty Rd. Randallstown, MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death Methadone intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED attending physician or use as the burial A#E53a,27,28a-f, perME,g871, 9/26/07 TT Box 68760, 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 🗸 Unknown of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of certificate has performed' Yes 2 V No 2 No 1 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: Other-Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Pending Yes 2 X No To the Funeral Director: filled in by the Fnd 9/10/2007 Fnd 9:30 am Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State)
1520 North Ave. Apt, 308 BAltimore, No. determined (Specify) found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 11, 2007 30. Name and address of person who completed cause of death (Item 23a Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Regetrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** PAULINE AYRES 01:46 AM SEPTEMBER 16th 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE 8. Date of Birth
(Month, Day, Year)
JUNE 26, 1913 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🙀 F 94 VA 217-22-0706 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Director GLEN BURNIE MD ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò be 7975 CRAIN HIGHWAY 21061 USA item 27 is marked other than "natural", or Items 23s other traumatic event, the Medical Examiner must 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FT. HOWARD HOSPITAL 10 DIETICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be ပ REUBEN CARRINGTON PEARL JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health ar item 27 is 993 JASON CT., GAMBRILLS, MD 21054 IMELA JONES/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD ARBUTUS MEM. PK. 09-24-07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H., INC. a. BALTIMORE, MD 1701-31 LAURENS ST. 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 YRS CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🛣 No 24a. Was an page 2 s autopsy 1∐ Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural Injury s after dean ral Director: Aftr 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier September 16th 2007 D0054739 verilin mo. onna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 204 Glen Burnie Maryland OAKWOOD RUAD 7845 32. Signature 31. Date filed (Month, Day, Year) SEP 18 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 98/1 9-18-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Voar Physician ABELOFF MARTIN 3:50 AM September 14 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospital HOOKINS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 04/04/1942 **Funeral** Days Months Hours 65 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 2213 SULGRAVE AVENUE 21209 USA Funeral death . Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 + n and Mental Hygiene. Elementary/Secondary (0-12) MEDICAL DOCTOR MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ **ABELOFF** ဥ AARON CELIA FREED 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau DIANE L. ABELOFF / WIFE 2213 SULGRAVE AVENUE, BALTIMORE, MD 21209 OHEB PARK 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 09/16/2007 REISTERSTOWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Kemix 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Lymphocytic 3monThs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1∐ Yes 2 XNo Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) To the l and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 14, 2007 ner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nina Wagner, MD. Johns Hopkins Hospital 600 North Wolfe Street Baltimore MD 21287 15 31. Date filed (Month, Day, Year) SEP 1 8 State Registrar

3. Time of Death

Funeral Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at ral", or items 23a or Examiner must be r Baltimore, Maryland 21215-0036 "natural", er than "natur , the Medical I

Physician

Physician /Medical Examiner

The law requires that the death certificate be executed physician and s the burial-tran certificate To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Sophia Rosalee Marwell Branch 1226 2007 6 /Medical 4a-Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MEDICAL SALIS BURY LENTER Wicomics FENINSULA REGIONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 212-36-7094 1□M 2√F April 3,193 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 □ No Director Wicomico Hebron Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Cedar Ct 21830 8048 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurses Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stoney ၉ Joseph Maxwell Marie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hebron 8048 C+. Daughter Cedar MD 21830 Debra Maxwell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry September 17,2007 Hoursver, NLD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Areatorny Gifts Registry 21. Signature of Funeral Service Licensee 1522 Connelley Drive SuiteP. Hanover, MB 21076 23a. Part1. Enter the Thease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of lighty that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 2XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D., SEPT. 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E CARROLL St. SAlisbury Md 21801 MD PhD 100 SWIERKOSZ

State

Registrar

31. Date filed (Month, Day, Year)

SEP18

within 24 hours a

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29756 State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 11150 PM Dolores September Gertrude Buchacz 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1151 St. Catherine Drive Anne Annapolis

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Arunde 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 75 216-28-4560 Director Maryland June 22, 1932 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Nes 2 No Anne Arundel Directo Maryland Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code St. Catherine USA 1151 21401 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Home marker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elanore Joseph Gorecki Bonnet 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert Buchacz Husband 1151 St. Catherine Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry September 10/2007 Marioves 1 September 16,2007 Hanover, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 7522 Connelley Drive Suite P. MD 21076 Hassover, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 2120989 03720 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe this certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: completely filled in by the funeral director, after death

> State Registrar

29a, Certifier

29b. Sign

31. Date filed (Month, Day, Year SEP 1 8 2007

and title of certi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes as a

			for State Registrar	State of IVI	aryland / I	Depa <i>Cei</i>	artment of F rtificate of I	lealth an Death	d Mental H	ygien Reg. N	2007	29757	
-	Physici	an	1. Decedent's Name (First, Middle	Last)					2. Date of Month		ay Year	3. Time of Death	
4	/Medic			checiamp					Septe	mber	10 200		
	Examir	er	4a. Facility Name (If not institution, Holy Cross Host	1			4b. City, Town, or			40	c. County of Dea		
	Funeral	20.00	5. Social Security Number		e (In yrs. last bii	rthday)	S1LVE	r Sprin	Hrs. 8 Date of I	Montgomery Birth 9. Birthplace (State or Foreign			
Adelase	Director		110-30-4962 Usual Residence of Decedent	X □M 2□F	69	Yrs.	Months Days	Hours N	Month, Sept.	Day, Year 18]	L937 New	York	
	yland now at		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits	
	e Mar 3a-f sl tiffied	Director	MD Howar	rd	Laur	el						1 □Yes 2X No	
	vith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
	sath v	eral	9208 Sewall Ave	12. Was Decedent	Ever in II S	12.1	207) (Canally Van av	Na T	USA 14. Race - Ame	orioon Indian	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	Armed Forces?			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XXNo	Specify:	uerto Rican, etc.)	NO-	Black, Whit		
5-0	72 ho 'natur dicat	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a	. Deced	dent's Usual Occup	ation durina most of	workina	16b. i	Kind of Business	/Industry	
12	vithin ine. ihan "	mple	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done of OO NOT use retired		······································	Co	rranth D	av Adventist	
р Б	filed v Hygie ther t	Co	12th 17. Father's Name (First, Middle, I	.ast)	5	enic	or Accoun		Name (First, Midd			ay Adventist	
an	lid be lental ked o	To Be	Anthony Frank E	Boccheciamp				Ethe	elvn Pre	tto	,		
ary	2 shou and N is man		19a. Informant's Name/Relationsh	ip (Type. Print)	195	. Mailir	g Address (Street				or Town, State, .	Zip Code)	
2	1 and 2 Health em 27 i		Lorraine Bocche	ciamp/Wife			Sewall A				20723		
Baltimore,	Pages 1 ment of H ant: If Ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation				sition (Name of natory or other plac	1	Date		_ocation - City or	Town, State	
븊	iit. Pa artmer ortant: injury		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		Georg	e Wa	ashington	Cem 9/	/16/2007	Ade	elphi, M	D ome, P.A.	
Ba	permit. Departn Importa any inju		1 Get Su		M00770		L3 Talbot						
	\$ - 10 mg		23a. Part1. Enter the disease, of shock, or heart failure. List	complications that caused	the death Do						2010	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Seps								Onset and Death	
	/Medical Examiner		Due to (or as a consequence of): Respiratory Failure										
9	S. S	_	Sequentially list conditions,	D	iratory		llure						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		monia	01).						>	
o,	execu an and rial-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):							
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õ ×	± 0,0		IF FEMALE:	23c. If yes, outcome	,					- 1			
.O. Box	The law requires that the death cert the has been signed by the attending age 2 should be detached for use it	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23d. Date of delivery Month Day Ye								
ω, σ	s that ined b e deta	y P	Part II. Other significant conditio	ns contributing to death be	ut not resulting in	n the ur	nderlying cause give	en in Part I.	23e. Die	d tobacco	use contribute to	o the cause of death?	
ğ	w require been sig should b	ted t	Parkinson's Dis	ease					_ 1[Yes 2	2 □ No 3 □ P	robably 4 🛛 Unknown	
Vital Records,		Completed by							pe	as an topsy rformed? ; 2 🔀 N	prior to death?	utopsy findings available completion of cause of	
=	Physiclan: Thr r this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 [X] No	Hospital:	-t 0.0.50/0	tastian	t 3D DOA Othe	ar.	Death (Check onl)	-			
0	g Phy er this eral di	<u>ٿ</u>	27. Manner of Death	28a. Date of Inju		Time of	O DON	4 LI Nursin	g Home 5 ☐ Re 28d. Describ			ecify)	
0 I	ath. ath. r: After re funer	atio	1 X Natural 5 Pending 2 Accident investigation	ation	(Year)	Injury		<br Yes 2 □ No					
Division or	al or Attend after death Director; d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of inju- building, etc	ry - At home, fa c. (Specify)	ırm, stre	eet, factory, office		28f. Location City or 7	(Street a own, Stat	ind Number or Rite)	ural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certificacompletely filled in by the funeral director,	Medical C	29a. Certifier 1 ☐ Certifying (Check only one) 1 ☐ Medical E	Physician: To the best of the basis of the b	examination ar	e, death	occurred at the tin restigation, in my o	ne, date and pl pinion, death o	ace, and due to the	ne cause(s e, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)	
	To the I	Ň	29b. Signature and title of certifier				29c. License	e number		29d. Da	ate signed (Mon	th, Day, Year)	
	0		MIN	tame			D3:	2332		Sep	tember 3	11, 2007	
10	0		30 Name and address of person v										
	Sta	te	Dr. Gupta, MD 31. Date filed (Month, Day, Year)	9801 Geog	rgia Ave ar's Signature	enue	, Suite	220, Si	lver Spr	ing,	MD 2090	02	
	Registr		SEP1 8	2007	ar's Signature	P	and a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Miriam Jeanne Brannon 5:00 A^M September 15, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 505 Bathurst Road Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗗 F Months Hours Director 233-28-7226 April 9, 1923 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 505 Bathurst Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No þ Specify: White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. other than Statistician State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h Wyatt Whitehead Lipscomb Mary charlotte Popeii 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Lynne Yoe Daughter 505 Bathurst Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/17/2007 lnjury (Metro Crematory 4 Donation 5 Dother (Specify) Catonsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses any In hand 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweei Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** UNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 autopsy s certificate ha 2□ No 1∏ Yes 2 X No director, 25. Was case referred to medical 26. Place of Death (Check only one) PAUGHTERS Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3∏ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After LYNNE YOE 1 Natural 5 Pending Injury Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director;
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

COLE 31. Date filed (Month, Day, Year) 1 8 2007

29b. Signature apartile of certifier

4 Homicide

29a. Certifier (Check only

> AGNES Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE BALTIMORE MD 21229

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dav. Year)

			For State Registrar	State of Ma	aryland		irtment <i>tificate</i>					jiene eg. No.			
			Decedent's Name (First, Middle, La	st)						2.	Date of Dea	th Day	Vaar	3. Time of Death	
	Physici		Robert D. Bro	okman						S	Month eptemb		3, 200		
	/Medic Examir		4a. Facility Name (If not institution, given	e street and number)			4b. City, T	own, or	Location of		•		County of Dea		
			Greater Baltimo	re Medical	Cent	er	Tows	on				Ва	ltimor	e	
	Funeral		,	Sex 7. Ag	e (In yrs. la:		If Under 1 Months	Year Days	If Under	Min.	Date of Birth (Month, Day	Year)	9. Bi	nthplace (State or Foreig ountry) Maryland	
L.	Director		213-60-7084	16 M 201	53	Yrs.	-			F	lug. 20	J, 15	954	Marylanu	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				·····			10d. Inside City Limit	
	Marylan f ehow	ō	MD Baltim	ore	To	nson								1 ☐ Yes 2 No	
	72 hours after deeth with the Maryland Insturel', or Items 23s or 28s-f show Licel Examiner mast be notified at	Director	10e. Street and Number				10f. Zip 0	Code			1	I0g. Citiz	en of What C	country?	
	3a o		2007 Indian Head	Road			21	204				US	SA		
	deeti	nere	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Vas Decede	nt of H	ispanic Ori	gin? (Specify	Yes or No-	1	4. Race - Am Black, Wh	erican Indian,	
0	after or It	교	1 ☐ Never Married 2 💢 Married	1 ☐ Yes 2 💢	No				Specify:		a., o.o.,		Specify:	White	
3	72 hours "neturel",	d b	3 Widowed 4 Divorced	Year or Dates:											
5	neti	ete	15. Decedent's E (Specify only highest gr			(Give	lent's Usual kind of work DO NOT use	done	during mos	t of working		16b. Kin	nd of Busines	s/Industry	
21213-0030	within iene. then	Completed by Funeral	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Sal		1011160	"/				Auton	notive	
2 4	Hygie Hygie other	ပို	17. Father's Name (First, Middle, Las.		1	001			18. Mothe	er's Name (F	irst, Middle,	Maiden S	Sumame)		
0	should be and Mental is marked of sumatic sve	To Be	Sherwood Brook	man					Cyr	nthia	ia Jones				
Maryland		-	19a. Informant's Name/Relationship	Type, Print)									Town, State,		
			Sandra Amos-Broo	kman (wife	2)	200	7 Indi	lan	Head	Road,	Towso	n, M	Marylar	nd 21204	
2	Pages 1 and 2 nent of Health int: If Item 27 I		20a. Method of Disposition ★★Bunal 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci		cer	netery, cren	sition (Name natory or oth emeter	ner plac	ce)	Date 09/18,				r Town, State Maryland	
baltimore,	permit. Page Depertment of Important: If eny Injury or		21. Signature of Funeral Service Lice	Il New	8/	1	050 Yo	ork	Road	, Tows	on, Ma	ryla		Home, Inc. 204	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death.	Do not ent	er the mode	of dyin	g, such as	cardiac or re	espiratory arr	est,		Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) A Due to (or as a consequence of):									H8 Nouv			
	Examiner														
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	nce of):									
D.	xecuted and I-transit	xamin	that initiated events	c											
	e exe ien ar irial-t	ш	resulting in death) Last	Due to (or as	a conseque	nce of):									
09/90	icate be ex physicien a s the burial	ca		d											
õ	e as t	Mec	IF FEMALE:												
O. Box	e death certificate be ex the ettending physicien hed for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe		,			2	3d. Date of d Month	elivery Day Year	
Ţ.	thet the de ted by the e detached t		Part II. Other significant conditions	contributing to death b	ut not result	ing in the u	nderlying ca	use div	en in Part I		23e. Did to	bacco us	se contribute	to the cause of death?	
ords,	w requires the been signed I should be det	ted by									1 🗆 Y	es 2	No 3□	Probably 4 Unknow	
Vital Records,	The lay	Completed									24a. Was a autop: perfor 1 Yes	sy	death?	autopsy findings available completion of cause of	
<u> </u>	ysician: T	Bec	25. Was case referred to medical examiner?						26. Place	e of Death (C	check only or	ne)			
> 5	S 0 D	2	1 Yes 2 No	Hospital: 1 1 Inpatie		R/Outpatien		_	4 LINU	ursing Home	5 🗌 Resid	ence 6	○ Other (Sp	ecify)	
	ding After fune	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) 2	8b. Time of Injury	м 28	C. Injur Wor	yat k? Yes 2□		f. Describe h	ow injury	y occurred		
=	al or Attendes of the control of the	Certification;	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 289. Place of Injury - At home, farm, street, factory, office City or Town, State)							Rural Route Number,					
	o the Hospital or At ithin 24 hours efter of the Funeral Direct ompletely filled in by	edicai	(Check only 2 Medical Exa	hysicien: To the best miner; On the basis o and manner st	f examination		vestigation,	in my o	pinion, dea		at the time, o	date and	place, and d	ue to the cause(s)	
	TETE	2	29b. Signature and title of certifier				200	LICORE	e number		1 2	29d Date	e signed (Mo:	TO LIGH YAS!	

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicia within 24 hours elter death.

To the Funerel Director: After this certicompletely filled in by the funeral director

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year									
Part II. Other significant conditions or	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner?	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home	5 Residence 6 Other (Specify)									
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	d. Describe how injury occurred									
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one)	ysicien: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)									

29c. License number

20051347

10 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

C. Smalls

SEP 1 8 2007

Division or Vital Records, P.O. Box 68760.

State Registrar DHMH 17 Rev 1/2001

10

IREDELL W. 31. Date filed (Month, Day, Year) SEP 18

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

CHARLES ST. BALTO., MD. 21212.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29761 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Year **Physician** Alan Beebe 12:29 A M 2007 /Medical 0 Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days XXM 2□F Months Hours Min. 454-21-0378 49 Director 10-20-1957 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1√Xes 2□No N/A Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 4705 Pilgrim Road 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural" or iten edical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married $V = S \mathcal{L} \mathcal{L} \mathcal{B} \mathcal{L}$ Maryland 21215-0036 1 ☐ Yes 💢 No Specify ð Specify: 3 ☐ Widowed ★☆ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packer Moving & Storage 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beebe Julia Irene Freeman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or any injur Raffaella Spinnichio 4705 Pilgrim Road Baltimore, MD 21214 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ZECremation 3 ☐ Removal from State 9/18/2007 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211
Approxima 21. Signature of Funeral Service Licensee 23a. Tart1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner GRENIOUS CHOLECYSTITI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atter Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown NICEACE 2 should OAGULOPATITY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? s certificate ha lirector, page 2 1∐ Yes 2 DN6 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2□ Mo 1 ☐ Impatient 2 ER/Outpatient 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOO SEPTEMBER, 17,2007 HANDA WASSEM GOODSAMARITAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 56 € BLUD, BALTIMORE, MA, 21239

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Months Pap

RR

gistrar's Signatur

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Mar		Certifica			Mental Hy	Reg. No.	007	29762
3	Physici		1. Decedent's Name (First, Middle, Las	st)					2. Date of Do Month	Day	Year	3. Time of Death
	/Medi Examir		Paul Baker 4a. Facility Name (If not institution, give	e street and number)		4b. Cit	ty, Town, o	r Location of Dea	-	/	ounty of Death	1 1
		М	Manyland 6. S. Social Security Number 6. S	neral He	sprtas	L La	lf// der 1 Year	70RL (ity			
	Funeral Director			NA SOLE	*	month Month		Hours Min		ay, Year)	9. Birthpl County Mary	
	iryland show	_	10a. State 10b. County	10	0c. City, Town						10	Od. Inside City Limits
	the Ma 28a-f s notified	ecto	MD 10e, Street and Number		Balti		Zip Code			10- 60-	-434/140	1 Yes 2 No
ī	ath with \$ 23a or nust be r	Funeral Director	3010 Clifton Ave				2	1215			of What Coun	
Mer 3036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportment if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.		cedent of Hoecify Cuba 2 1 No	Iispanic Origin? (i an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		Race - America Black, White, e pecify: b1	
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2 pu	be file tral Hy id othe event,	Be	17. Father's Name (First, Middle, Last)				unk	18. Mother's Na	me (First, Middle	, Maiden Su	rname)	unk
Raryland	should nd Mer marke imatic	ြ	19a. Informant's Name/Relationship (7	Type. Print)	19b. I	Mailing Addre	ss (Street	and Number or F	ural Route Numb	ner. City or To	own State Zin	Code)
, Me	and 2 sealth and 2 is n 27 is ser trat		Ardie Shaw/Comm o							on only or re	own, olato, zip	unk
Baltimore,	Pages 1 tment of He tant: If Iten jury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ▼ Other Specify	Removal from State	20b. Place of I cemetery	Disposition (N crematory o	lame of r other plac	ce)	Date	20c. Locat	ion - City or To	vn, State
Bal	permit Depar Impor any In		21. Signature of Emerci Spice Licen	Wad , Direc	ctor	22. Name State Balti	Anat	ss of Facility Omy Boar MD 212	d 655 W	. Balt	imore S	treet
			23a. Part I. Enter the disease, or companies, or heart failure. List only	olications that caused the one cause on each line	e death. Do no					arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Duesto for as a co	776/	micol	ect	omy				Onset and Boath
	Examiner		Sequentially list conditions	b. Ascend	ing (Color	2 C	ance,	R			
	ted rsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):						
oʻ	rificate be executed ig physician and as the burial-transit	Exar	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):						
68760,	cate be ohysiciathe the contraction that the but	Aedical	•	d								
9 X C		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p	oregnancy					224	. Date of deliver	
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or	ding Phys n. After this funeral dii	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tir	ne of	28c. Injur Worl	4 LI Nursing F	Home 5 ☐ Resi 28d. Describe)
Si j	tendir leath. tor: Af the ful	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	u		М	1 🗆	Yes 2 No				
Divi	after d after d I Direc d in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	- At home, farm Specify)	i, street, facto	ory, office		28f. Location (City or To	Street and N wn, State)	umber or Rural	Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifying Phy (Check only one) Medical Exam	'/sician: To the best of m iner: On the basis of exa and manner stated	amination and/	death occurre or investigation	ed at the tin	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as sta ace, and due to	ated. the cause(s)
	To th Vithir Comp	Me	29b. Signature and title of certifier	1.			9c. License	e number		29d. Date si	igned (Month, E	ay, Year)
		-	·VV		SI, MD		8	4612		9,	110/07	P
			30 Name and address of person who de NaRe SN Bas	ompleted cause of death	(Item 23a) (T	/pe, Print)	2R4	land (Sener	al i	HOSP	ral
	Sta Registr		31. Date filed (Month, Day, Year) CFD 1 8 20	32 Registrar's	Signature	hails?	,					

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death	29763					
	Physic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Oay Year	3. Time of Death					
	/Medi Examir								
26	Funeral Director	R	Good Samaritan Hospital 5. Social Security Number $099-20-1121$ 099-20-1121 099-20-1121	thplace (State or Foreign ountry) unk					
	yland yow at		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits					
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timor	t. Pages tment of tant: If it ijury or o		4 Donation MOther (Specify) in state	Town, State					
Ba	permi Depar Impor any ir		21. Square of Euror Service Licensee Ronald S. Water Director State Anatomy Board 655 W. Baltimore Baltimore, MD 21201	Street					
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death					
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	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Christiphy. Cause (Disease or injury						
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.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	ivery Day Year					
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27. Manner of Death 28a. Date of Injury 28b. Time of Injury									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; it	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as and manner stated.	stated. to the cause(s)					
	To the within To the Comple	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)	n, Day, Year)					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10,07					
			Khos row Tabassi, Good Samaritan Hospital; Baltimore, MD	21239					
	Sta Registra		- 4 D OCCUPATION OF MARKET I						

Mary Brown

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician ARTHUR LEROY BENEDICT 14, SEPT 2007 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL HOSPICE - DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1₩ M 2□ F Days Hours Min. 220-18-2369 Director 82 11/16/1924 MARYLAND Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or traumatic event, the Medical Examiner must be 47 S. COLONIAL AVE. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. should be filed within 72 hours after of Mental Hygiene.

marked other than "natural", or ite 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE 12 AUDITOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JESSE MILTON BENEDICT LOTA ZERELDA SYKES P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun MILDRED E. BENEDICT -WIFE 47 S. COLONIAL AVE., WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State KRIDER'S CEMETERY 9/18/07 WESTMINSTER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Signatural Funer Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive heart disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran and Due to (or as a consequence of): Box 68760 physician pe Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Known 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ØOther (Specify) 1 TYes P funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/14/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster Md. 21157 555 3. Street lo M.D. Canter 31. Date filed (Month, Day, Year) 32. Relistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20071 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year BARIS Florence D. 6:54 AM 4c. County of Death September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINA BALTIMORE HOSPITAL N/A OF BALTIMORE 5. Social Security Number If Under 1 8. Date of Birth 06/20/1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 👿 F 218-12-7316 84 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Director MD 1 Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 PARK HEIGHTS AVENUE APT. #206 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ģ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **BOOKKEEPER** SINAI HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUBIN DAVIDSON IDA KOHEN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID BARIS / HUSBAND 6317 PARK HEIGHTS AVE. APT. #206-BALTIMORE, MD 21215 BETH BLY, MEMORIAN Place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RANDALLSTOWN, MD 09/16/2007 4 Donation 5 Other (Specify) f Fungral Service Liceo 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complicate shock, or heart failure. List only on ous that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC Physician o months CANCER WITH METASTASI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examine if any Lating cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 □ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed DIABETES MELLITU 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has lirector, page 2 s autopsy perform 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed filled in by e Funeral i within 24 hor To the Function

FLORENCE

State Registrar

Medical

29b. Signature and title o D.O, Ph. D

RES 000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ph.D. Sinai Hospital of BALTIMORE, 2401 W. Belveder AVE, BAITIMORE, MD 21215 PAUL AGUN, D.O.

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

31. Date filed (Month, Day, Year)

29a. Certifier

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		State of Maryland / De		Montal Hygiana	9		
		1 - State Registrar Co	ertificate of Death	Reg. No.	2007 29766		
Physici /Medic		Decedent's Name (First, Middle, Last) RUTH	BLICKMAN	2. Date of Death Month Day SEPTEMBER 1	7, 2007 3. Time of Death 1:30A M		
Examin	er	4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER	4b. City, Town, or Location of Deatl BALTIMORE	h 4c.	4c. County of Death BALTIMORE		
Funeral Director		5. Social Security Number 129-03-3918 6. Sex 1 M 2 K F 7. Age (In yrs. last birthda 93 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 05/16/1914	9. Birthplace (State or Foreign Country)		
vland ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits		
he Mary 28a-f sh otified	Director	MD N/A BALTIN			1 X Yes 2 No		
th with t 23a or 2 Ist be n		6401 LOCH RAVEN BLVD., APT. #307	10f. Zip Code 21239	10g. Citiz	zen of What Country? USA		
ter dea items	Funeral	11. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. □ Never Married 2. □ Married 1. □ Yes 2. ☑ No 1. □ Yes, Give	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.		
If it is in the Maryland flied within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural" or items 23a or 28a-f show not, the Medical Examiner must be notified at	b	Teal of Dates.	1 ☐ Yes 2 🗖 No Specify:		Specify: WHITE		
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1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. Health and Mental Hygiene. The first marked other than "natural" or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	To Be	LOUIS ROMASK	A ROSI		UNOBTAINABLE		
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S to the s			position (Name of ematory or other place) SERVICE CORP. 09/1		cation - City or Town, State WSON, MD		
permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee	22 Name and Address of Facility		& BROS., INC.		
9 10 2 10 0		23a. Part . Enter the disease, o/complications that caused the death. Do not esh. k, or is art failure. List or y one cause on each line.	8900 REISTERSTOWN nter the mode of dying, such as cardiac	ROAD - PIKE or respiratory arrest,	Approximate		
Physician		Immed te Cause (Final disease or condition resulting in death)	ARDIOMYOPHTHY		Interval Between Onset and Death		
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ured in sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
S Sign De	al Exa	resulting in death) Last C. Due to (or as a consequence of):					
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The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the the table.	Physician/Medio		□Ectopic pregnancy □ Other (specify)	2	3d. Date of delivery Month Day Year		
w requires that s been signed be should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the HAPERTENSION	underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?		
has been ye 2 shoul	Completed	ABDOMINAE ANEURYSM		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
ding Physician: The In. Affer this certificate he funeral director, page		25. Was case referred to medical		performed? 1□ Yes 2□ No	death? 1 Yes 2 146		
nysicla nis cert direct	To Be	examiner? 1 Yes 2 No		th (Check only one) ome 5 ☐ Residence 6	i ∐Other (Specify)		
Attending Physician: r death. ector: After this certifice by the funeral director, r		27. Manner of Death UNatural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) (Month, Day Year) Injury	of 28c. Injury at	28d. Describe how injury			
or Atter after deal Director In by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,		
	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de- 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)		
To the within 7 to the comple	Mec	29b. Signature and title of certifler	29c. License number	29d. Date	e signed (Month, Day, Year)		
		Jasnem Lallrami	D28595	9/1	7/07		
3		30. Name and address of person who completed cause of death (Item 23a) (Type TASNETM CAKHANI, 2835 Sm 177+) 31. Date filed (Month, Day, Year) SEP 1 8 2007 32 Jegistrar's Signature	AVE, SLITE 253	, BALTO N	1) 21208		
Sta Registra	_	31. Date filed (Month, Day, Year) SEP 1 8 2007 32 degistrar's Signature	books				
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			1 - For State Registrar	State of M	arylar		artment of <i>tificate of</i>					200	7 291	7 5
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	∍Physic /Medi	cal	MARIAN		LAYI	ON	4. 6: 7			SEPT.		200 ^{Year}	12:15	э ^м
)	Examii	ner	4a. Facility Name (If not institution, HOLY CROSS H	,	,		4b. City, Town, SILVEI					County of Death	DV CO	
48	Funeral		5. Social Security Number 6			last birthday)	If Under 1 Yea Months Days	r If Under 2		. Date of Birth (Month, Day	1		place (State or Fo	<i>reig</i> n
À.	Director		238-68-0293 Usual Residence of Decedent		68	Yrs.			1	1-30-	-193	88 N.	C	
nelvae	show d at	_	10a. State 10b. County			ty, Town or Lo							10d. Inside City L	
the M	28a-f	Director	MD MONTGO	OMERY	S	ILVER	SPRING 10f. Zip Code	3			LOa Citi:	zen of What Cou	1X Yes 2[7140
th with	23a or ıst be	al Di	13203 TAMAR	ACK ROAD			,	20904				.S.A.	, .	
036 III's after dea	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? d 1 Yes 211 If Yes, Give Year or Dates:	?	ı	Vas Decedent of f Yes, specify Cu I ☐ Yes X No		gin? (Specif i, Puerto Rid	fy Yes or No- can, etc.)	1	14. Race - Americ Black, White, Specify: BL	etc.	
5-0-2	'natur dical B	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual Occu kind of work done OO NOT use retire	upation e during most	t of working		16b. Kind of Business/Industry			
21215-0036 d within 72 hours at	within ene. than " he Mec	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		NOT use retir VRITER	ed)				PRIVAT	.	
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Maryland	d Mental narked o	T ₀	WILLIAM	LOWELL	SM	ITH			RRIE		NAN			
	जु हु ज		19a. Informant's Name/Relationship VERNON CLAYTON									Town, State, Zip		
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i i	and the land		4 ☐ Donation 5 ☐ Other (Spe	ecify)	GA		HEAVEN		9-18	-2007	SI	LVER S	PRING,	MD
Balt	Depa Impo any i		21. Signature of Funeral Service Li	nensee O			. Name and Addr 08 W . N						FUNERAL	
1	nysician /Medical xaminer		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sacral Decubitus											n
. w		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseq									
y. ecute	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Stroke		uence of):								
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	ing ph) e as th	Medi	IF FEMALE:											
.O. BOX 6	been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Feta	al death 3 🗌	Ectopic pregnand Other (specify) _	су			2	3d. Date of delive Month	ery Day Year	1
Hecords, P.	en signed b	by	Part II. Other significant condition	s contributing to death b	out not res	ulting in the un	derlying cause gi	ven in Part I.				se contribute to to	ne cause of death pably 4凇Unkr	
	ate has page 2	Completed								24a. Was a autops perforr 1∐ Yes		24b. Were auto prior to co death? 1 □ Yes	psy findings avai mpletion of cause	lable of
VISION OF VITAL Attending Physician: T	s certifi lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	ant 2□	ER/Outpatient	3□ DOA Ot	hor:		Check only on				
n Or 19 Phy	After this funeral di	\vdash	27. Manner of Death	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury	28c. Inju	4 □ Nur		J. Describe ho		Other (Special	<u>y)</u>	
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he Hospita	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical C	29a. Certifier (Check only one)	Physician: To the best caminer: On the basis o and manner st	f examina	wledge, death tion and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, and th occurred	d due to the ca at the time, d	ause(s) ate and	and manner as s place, and due to	tated. the cause(s)	
Tot	To t	Ž	29b. Signature and title of dertifier	1.11 M	. 1	1/1.	29c. Licen	se number	7/1	2:	9d. Date	signed (Month,	Day, Year)	
	_		30. Name and address of person wh	no completed cause of d	leath (Ito~	23a) (Time 5	11 100	2091	14		9	14/20	700	
	10						o., SII	VER S	PRIN	G. MA	RYT.	AND 20	910	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 1 - For State Registrar 29768 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Year September 16 9:03 AM viane Carpente 2007 /Medical 4a. Facility Name (If not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Northwest Center Baltimore andal stown 5. Social Security Number If Under 24 Hrs. 6. Se 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 □ M 2 🗶 F 47 212-86-0662 Director 1**-**11-1960 Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Baltimore Owings Mills be notffied 1 ☐ Yes 2 No Director permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f any Injury or other traumatic event, the Medical Examiner must he marked once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 Willow Branch Way, Unit 301 21117 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nutritionist Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Bennett Christine Carrico P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geoff Carpenter/Former Husband 4003 Cloveland Drive, Phoenix, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Hilltop Service 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9-19-2007 4 ☐ Donation 5 ☐ Other (Specify) Corporation Towson/MD 21. Signature of Funeral Service Licences Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic brain /Medical Due to (or as a consequence of): Examiner lultiple organ system talure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner activity cardiac arrest The law requires that the death certificate be executed pulseless burial-trar Division or Vital Records, P.O. Box 687605 physician at the burial attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 alcoholism 2 No 1 Tes 3 Probably 4 Unknown Completed gastrointestina 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has b irector, page 2 s hemorrh 24a. Was an autopsy performed? Yes 2 **D** No 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manyler of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 16 2007 Joston D 28462

State Registrar

31. Date filed (Mont

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Hospital Center Randallstown, Maryland 21133

erson who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Year Month RALPH COOK 3 SIM or Location of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, 4c. County of Death TiMore THORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/26/1929 9. Birthplace (State or Foreign Country)
S. CAROLINA Social Security Number 'yrsi. I **77** Days Months Hours 1**X** M 2□ F 217-24-1924 S. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD BALTIMORE CITY 1 to Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3802 HILLSDALE ROAD 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 7TH CHAUFFEUR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JIMMIE COOK ETHEL KENNEDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY C. COOK / WIFE 3802 HILLSDALE ROAD, BALTIMORE, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/19/07 KING MEM. PARK WINDSOR MILL, MD 21. Signature 6 uneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the visease, or complications that caused the deal or heart rilure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death diate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 TYes 24a. Was an autopsy perforn 24b. Were autopsy findings available prior to completion of cause of death? 2□No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 2 □ No 1 Tes Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

be executed attending physician for use as the buria signed by the a P.0. or Vital Records, page 2 director, this After Hospital or Attending the 24 hours after death Funeral Director; filled in by

Physician/Medical Certification: To

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29a. Certifier

(Check only one)

and manner stated. 29b. Signature and title of certific

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person v

Date filed (Month, Day, Year

32. Régistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEN TIEWES 28f, perHYS. 871, 9/19/07, WS
State of Maryland Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 55 PM romp /Medical 4a. Facility Name (If not institution, give street and number) Location of Death 4c. County of Death **Examiner** HOSPICE 41001 If Under Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde 24 Hrs. Min. **Funeral** Months Days 1 M 2 □ F -36-537 68 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 res 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KDac ચાત્રવ Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [v If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>Ş</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (9-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Baral Route Number, City or Town, State, Zip Code) neatham md 20c. Location - City or Town, State 20a. Method of Disposition ace of Disposition (Name of emetery, crematory or other place) 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses Baltimere Matt P. he Baltimere, md 2122 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Concer LUNY M Melopathe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed use as the burial-trans and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ģ in the past 12 months? Month Day Year n signed by the at Id be detached fo 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown de la Completed should Trypotrosim 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has page 2 autopsy perform Bleening ylen 1□ Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Qther (Specify) KPECOL 1 Tes 2[**X**No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Section funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending ↑ Natural 2 Accident 5 Pending investigation HOSPKÉ death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brextie 31. Date filed (Month, Day, Year) Registrar's Signature State 3 1 Mark. Registrar 2007

death:

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1 - State Registrar Certificate of I		1
Physician BETSEY CLARY	Month Day Year	
Micarda	SEPTEMBEL 6, 2007 1254 A or Location of Death 4c. County of Death	
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Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days		reign
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	10d. Inside City Lin	nits
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MiD Anne Arundel Pasadena 106. Street and Number 106. Zip Code	10g. Citizen of What Country?	
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8338 Catherine Ave 21122 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hill Yes, specify Cuba	dispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
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William Clark 8338 Catherine A	Ave, Pasadena, MD 21122	
U = ∓ m = 20a Method of Disposition 20h Place of Disposition (Name of	Date 20c. Location - City or Town, State	
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21. Signatura o Funeral Service Licenses 22. Name and Address	sap Fight, P.A.	
r Ka Gregory Pink M)1148	Hwy S., Glen Burnie, MD 21061	
23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Onset and Death	
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Examiner		
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The past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify)	23d. Date of delivery	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 550 AM 07 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale FRANKLIN HOSPITAL Square CENTER BAITIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 219-10-2136 1 ■ M 2 ■ Months Days Hours Min. 3 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A RIVE 21221 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales 6 RSON 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname KNOWles Taric HECKMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Brancheck Rosedale, ND catherwood 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-15-07 Sykesville, MD 21. Signature of Funeral Service Ligensee adley-Ashten Funcal Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Due to (or as a consequence of): Cancer Lung Due to (or as a consequence of):

Physician /Medical Examiner

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physician s the burial

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page 2 s

funeral director,

certificate

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After t

ye Funeral Director: Are Funeral Director: Are Funeral Director. Are filled in by the fu

within 24

completely

Physician:

Hospital or Attending

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10a. State

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at

21215-0036

Maryland

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examiner

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 menths? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner?

2 No

1 ☐ Yes

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Natural

ChRONIC Due to (or as a consequence of): estive

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death

Renel HearT

3 ☐ Ectopic pregnancy

5 ☐ Other (specify)

insuffienc Failure

> 23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

9□Unknown

24a. Was an autopsy performed?

1 | Yes 2 | No 3 | Probably 4 | Hinknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 - No

26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work? 1 Tes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

RES 00000

2 ER/Outpatient 3 DOA

28b. Time of

Injury

29d. Date signed (Month, Day, Year) 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN Square Hospital Mohsilvi DR. Baltimore mo 21237 DR wasahaTh 31. Date filed (Month, Day, Year)

State Registrar

5 ☐ Pending investigation

6 Could not be determined



DHMH 17 Rev 1/2001

07-07021 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Antonio James Clyburn State of Maryland / Department of Health and Mental Hygiene 2007 29773 1- For State Certificate of Death Registrar Reg. No dent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day September 10, 29 v burr Medical Examiner Antoni o ames 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death 3621 Elmley Avenue N/A Baltimore 5. Social Security Number 6. Sex 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** If Under 24Hrs Director Months oreign Country) MD 215.88.5652 36 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA 28a-f show MD 1 Yes 2 No Baltimore. Director 10e Street and Number 10f., Zip Code 10g. Citizen of What Country? Avenue Elmler IJSA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Widowed Divorced Yes. Give Yea Yes 2 No specify Specify: Black \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most-of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 i rent of Health and Mental Hygiene. ant: If item 27 is marked other than " Construction 11th arade Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Clyburn vatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Slate Ardley Avenue Balto. MD 21213 Mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 St. Stanislaus Cenetery Baltimore, MD Department of Windson Donation 5 Other Specify 0 21. Signature of Funeral Service Licenses Vauchn. C. Breene Firmeral Baltimore MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Contact Gunshot Wound of Head Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,... if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED X AMENDED #20b,c,perFH,G871,9/18/07,WS 3 per me g872 10-30-07 vt 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 ✔ No 3 Probably 4 Unknown Completed has been si 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✔ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other, this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 2 1 V Yes No After th funeral 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Sep 10, 2007 Subject shot self Natural 0018 hrs within 24 hours after death.

To the Funeral Director: completely filled in by the fi neral Director: , filled in by the fi Pending Yes 2 V No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 3621 Elmley Avenue, Baltimore, MD determined (Specify) residence Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b, Signature and title of certifie

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State

Registrar

Assistant Medical Examiner

32 Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 10, 2007

200

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

			1 - For State Registrar		of Marylan		artment of F rtificate of		nd Me	ental Hyg	iene _{eg. No} 20	07	29774
5.	Physic	ian	 Decedent's Name (First, Middle, Julia Cartwright 	Last)						2. Date of Dear Month	th Day	Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, Alice Manor Nursin		mber)		4b. City, Town, o	r Location of E Baltim		09/	4c. Count	y of Death	190/1
	Funeral Director		5. Social Security Number 213-18-3744 1									9. Birthp Cour	lace (State or Foreign try) unk
	yland how at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	the Mar 28a-f sl	Director	MD 10e. Street and Number					Baltimor	e				1 √2 Yes 2 □ No
	h with i	al Dir	1215 Glenhaven Road	1			10f. Zip Code	21239		1	0g. Citizen of 【	What Cour JSA	itry?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ₩Widowed 4 □ Divorœd	12. Was Dec Armed Fo 1 Tyes, Gi Year or D	edent Ever in U. orces? 2 NNo ve ates:	- 1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin an, Mexican, F Specify:	? (Spec Puerto R	ify Yes or No- ican, etc.)	Bla	ce - Americ ck, White, Afric	
21215-0036	d within 72 h giene. r than "natu the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0,12) Unk	s Education grade completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of i)	f working	g unk	16b. Kind of E		dustry re City
Maryland 2	2 should be filed and Mental Hyg Is marked othe aumatic event,	To Be C	17. Father's Name (First, Middle, L	_{ast)} unk				18. Mother's	Name (First, Middle, I	Maiden Surnai	ne) U	nk
Mar	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationshi Artie Shaw / Guar				g Address <i>(Street)</i> outh Calver						•
ore,	ages 1 ar nt of Hea : If item 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			Place of Dispo	sition (Name of natory or other place	i	Da Da		20c. Location		
Baltimore,	g, 55 ff c		4 □ Donation 5 □ Other (Sp.	ecify)	Ma Ma		n Cemetery . Name and Addres		/21/2	1	altimore uneral N		
Ba	permit. Departr Importe any inji		21. Signature of Function & E.	Censee		22	638 N. Gi	,	reet;				21217
	Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a.Co	caused the death each line. Contact the death d	76	er the mode of dyin	g, such as ca	rdiac or	respiratory arro	est, salas	5	Approximate Interval Between Onset and Death
8760,		ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c										
P.O. Box 6	eath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			ite of delive	ry Day Year						
ords, P	w requires that the di been signed by the should be detached	b	Part II. Other significant condition	s contributing to de	eath but not resu	ulting in the un	derlying cause give	en in Part I.	_		oacco use con es 2 □ No		e cause of death?
) Division or Vital Records,	i: The law nicate has be	Completed				-				24a. Was an autops perforr 1□ Yes	ned?	death?	osy findings available npletion of cause of
Vit	ysiciar is certif director	To Be	25. Was case referred to medical examiner?	Hospital:	npatient 2	ER/Outpatient	3 DOA Othe			Check onl on e 5 ☐ Reside		or /Spacifi	4)
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Ojvis	l or Att after de Direct	ertific	3 Suicide 6 Could no 4 Homicide determin	~ Zoe, Place	of injury - At ho ng, etc. (Specif)	me, farm, stre	eet, factory, office	·	28	f. Location (St. City or Town	reet and Numi , State)	per or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical Co	29a. Certifier (Check only one) Certifying 2 Medical E	ka miner: On the b	best of my know asis of examination ner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and p pinion, death	lace, ar	nd due to the ca d at the time, d	ause(s) and m ate and place,	anner as si and due to	ated. the cause(s)
	To the within comp	M	29b. Signature and title of certifier	R			29c. License	number 74	25	21	9/17	d (Month,	Day, Year)
3	, ,		30. Name and address of person w	1 821	AL- FIL	torn &	+ hal	town	R	MD	2/20	/	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 8 2007 SEP 1 8 2007										

DHMH 17 Rev 1/2001

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Registrar

2007

Michael David Diangelo State of Maryland / Department of Health and Mental Hygiene 2007 29776 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September 4, 2007 1755 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death Anne Arundel Pasadena 219 Atlanta Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Director Country) 1 M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County Yes 2 No or items 23a or 28a-f show Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. White etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Yes 2 V No Yes 2 No specify. Widowed Divorced If Yes, Give Year \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 hours; ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natura or other traumatic event, the Medical Exami 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last h 11 111ams 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 Cremation crematory or other place) Removal from State View (remotori Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-ASLON 1.34 W 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a Narcotic intoxication (morphine) and cocaine use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician for use as the burial -AMENDED #23a,27,28a-f, perME,C871, 9/26/07 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year Live birth Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ş Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has 2 performed? death? ✓ Yes 2 1 🗸 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 After this 1 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Natural Director: Yes 2 X No Pending undetermined Fnd 9/4/2007 Fnd 5:00 pm Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be or Town, State)
219 Atlanta Rd. Suicide determined (Specify) To the Funeral Pasadena, MD found on a boat Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified O.C.M.E. September 5, 2007 Ma lask 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year SEP I 32. Re strar's Signature State Registrar

ORIGINAL

			For State Registrar	State of Mar	yland		rtment of H				ne 200	7 2	9777		
	Physici	20	1. Decedent's Name (First, Middle, Las	st)					Date of Death Month Day Year 3. Time of Death Month Day Year						
	/Media	al	Alice Virgin	ia Duddera	ar		4. 0: -		Sep		r 13,20	07 2	2:00 A. ^M		
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	Funeral		Gilchrist Center 5. Social Security Number 6. S		(In yrs. last	t birthday)	If Under 1 Year Months Days	If Under Hours		of Birth of Day, Yo	9.		State or Foreign		
100	Director		213-03-9442 1 Usual Residence of Decedent	□M 2 欠 F	88	Yrs.	Months Days		January			Maryl	and		
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	a-f sh	ctor	Maryland Harfo	rd	Aber	deen						1	∏Yes 2∏No		
	or 28	Director	10e. Street and Number	·	·		10f. Zip Code			10g	. Citizen of Wha	t Country?	-		
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21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		i	Yes, specify Cuba	Specify:	igin? (Specify Yes n, Puerto Rican, e	c.)		White, etc. White			
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Maryland	and s m		19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	Address (Street	and Numbe	er or Rural Route	Number, C	ity or Town, Sta	ite, Zip Code	9)		
as	E E		Mr. Glenn R. Dudde	erar (So			Park Bea	ich Dr	cive, Abe		n, Mary				
nor	ages int of H		1 XBurial 2 ☐ Cremation 3 ☐		cem	etery, crem	atory or other plac	· :	09/17/07			,			
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		WOOL		Cemetery Name and Addre						and 2120 ctors,In		
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			23a. Par 1. Enter the distribute, or composition ock, or heart failure. List only									App	roximate val Between		
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9 x	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome pf	pregnance	v					23d. Date of	f delivery			
Вох	death atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ♣o	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Month	-	Year		
P.O.	that the de led by the a detached	hys	9 ☐ Unknown	9□Unknown											
8,	res that igned be de	by P	Part II. Other significant conditions of DEMENTIA	ontributing to death but	not resultir	ng in the un	derlying cause giv	en in Part I	. 236		cco use contribu				
ord	w requir been si should I		DEMIENTIA			-			- -	1 🗌 Yes	21270 31	Probably	4 Unknown		
3ec	has b	Completed							24a	. Was an autopsy	24b. We prio d? dea	re autopsy fi r to complet	ndings available ion of cause of		
Vital Records,	iclan: The certificate has ector, page	e Co	25. Was case referred to medical				_	00 Pi		performe Yes 2	No 1	Yes 2□	No		
Ş	ysician: nis certific director,	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER	l/Outpatient	3□ DOA Oth	or:	e of Death <i>(Check</i> ursing Home 5 [e 60 Other	(Specify) H	OSPICE		
n or	ding Phys .r. After this funeral di		27. Manner of eath 1 ★Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injur Wor				injury occurred	ороску	00// 20		
Division	tendli leath. tor: A the fu	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M 1 🗆	Yes 2□							
Νį	or At after d Direct in by	rtifi	4 Homicide determined	28e. Place of injury building, etc.	y - At home (Specify)	e, farm, stre	et, factory, office		28f. Loca City	ation (Stree or Town, S	et and Number (State)	or Rural Rou	ite Number,		
u	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical Ce	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of niner: On the basis of e and manner state	examination	edge, death n and/or inv	occurred at the the estigation, in my o	me, date ar opinion, dea	nd place, and due ath occurred at the	to the cau	se(s) and mann e and place, and	er as stated. I due to the	cause(s)		
	To the within To the Complex c	Me	29b. Signature and title of certifier	220			29c. Licens		-	29d	. Date signed (/	Month, Day,	Year)		
	1-		100	())	~	_	200	6439	75	52	PTEME	ER 1.	3, 2007		
			30. Name and address of person who	completed cause of dea	ith (Item 23	3a) (Type, F	rint)								
	C.	10	DANIEUE DOBER 31. Date filed (Month, Day, Year)	NAW / M.D. E 32. Registrar	s Signatur	N CHI	9RLES 3.	T, 84	478 216	84.	LTIMA	E, MAD.	21214		
	Sta Registi			2007		10	Mag. N. 8								
DHI	MH 17 Rev 1/2	001	JEF I O	CUUI Juli	see .	6		-							
						OR	GINAL								

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certiff

Medical State

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year egistrar's Signature

ORIGINAL

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 11, 2007

Registra

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ling Li, MD

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Dogoon 0 こけみれしゅててど 0.7 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cromwell Genesis Nursing Center Parkville Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Director Dec. 27,1934 Maryland 213-32-4375 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d, Inside City Limits 10b. County Show ir than "natural", or Itams 23a or 28a-f show The Madical Examinant wat be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Baltimore Over1ea 10g, Citizen of What Country? 10f Zin Code 10e. Street and Number 430 Old Home Road 21206 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of neath and Mental Hygiene.
ant if item 27 is marked other then "natural", or lite
ary or other traumatic avant, fra Madical Entail item
ary or other traumatic avant, fra Madical Entail item ☐Yes 21 No 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: Specify: White 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Albert Peters Anna Adams 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Quinn-Daughter 449 Old Home Road Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8/15/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, MD 21206 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3145 SEPSIS Physician /Medical Due to (or as a consequence of) Examiner EXTMUMITY MUNTHS LOWEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PENPIDENAL VASCULAN ASTASE physician and the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 Unknown MBETES MELLITU Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an UN TIA cate has l autopsy performed 1 ☐ Yes 2 ☐ No 2 No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier leado me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FERROR DELGMO 8710 EMGE NO BAZT 32. gištrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Wayne Charles Edmonston 2007 29780 Certificate of Death Registrar L Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September 6, 2007 1115 hrs **Medical Examiner** Edmondson Charles 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 8116 Roanoke Drive Takoma Park Montgomery 9. Birthplace (State or 5. Social Security Number If Under 1 Year | If Under 24Hrs. Date of Birth(MM/DD/YYYY) 6. Sex 7. Age (In vrs. last birthday **Funeral** Foreign Country) Months Days Hours Director NOV 5 1964 N.T 146-68-3952 42 1 **X** M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2 No 28a-f show MD unk unk death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA unk 23я Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Armed Forces? 2 Married Yes Widowed Divorced If Yes. Give Year Yes 2 X No specify: Specify: White <u>چ</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) than Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within 7 ient of Health and Mental Hygiene. Int: If item 27 is marked other than unk unk 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ Dorothy McKenzie 726 Hilltown Pike, Line Lexington, PA 18932 sister 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State 20a Method of Disposition Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o 9/18/2007 Metro Crematory, Inc. Donation 5 Other Specify 21. Signature of Funeral Service Licensee H. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Williams 1 4 1 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line. /Medical Death Narcotic and ethanol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): or veg Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and Physician/Medical attending physician or use as the burial -X UNPENDED 9/18/07 TT / #23a,27,28a-f, perME,g873m 11/8/07 TT Box 68760. IF FEMALE: 23d, Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown the s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>о</u> ⋧ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 1 🗸 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica Division of Vital Be examiner? Other₄ Hospital: DOA Nursing Home 5 Residence 6 ✓ Other: Scene this Inpatient 2 ER/Outpatient 3 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Yes 2 X No I Director: unk Fnd 9/6/2007 FNd 10:55 am 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide or Town, State) 8116 Roanoke Dr. Takoma Park. MD within 24 hours a To the Funeral I (Specify) found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Day Year) 29b Signature and title of certifie 29c. License number September 7, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) 32. Régistrar's Signature Registrar

DHMH 17 Rev 1/2001 OCME 2006

ANGEL Lee Folger

O7-07040

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK

State of Maryland / Department of Health and Mental Hygiene

2007 29781

	1- For State Registrar		Certin	ficate of	Death		Re	g. No.	.001 2310		
Physician/ ledical Examiner	1. Decedent's Name (F	First, Middle,Last) Lee Fogler	Angel L. Fol	ger		2. Date of Death Month September	Day Year 10, 2007	3. Time of Death 1324 hrs			
		ot institution, give street an Aven∪e & Potee Stre		4	b. City, Town, or L Baltimore			4c. County of N	Α		
Funeral Director	5. Social Security Num Unknown	6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Min	1, 1974	9. Birthplace (State or Foreign Country) MD		
nd show any, ree,	MD	b. County N/A	10c. City, To	own or Location	Baltim	ore		1	10d. Inside City Limits 1 XYes 2 No		
the Maryland a or 28a-f shudified at once	10e. Street and Numb 715 East	Patapsco Ave	enue		10f. Zip Code	21225		og. Citizen of Wha Unite			
urs after death with the Maryland tural", or items 23a or 28a-f slin aminer must be notified at once to by Funeral Director	3 Widowed	2 X Married Arme	Armed Forces? If Yes Yes 2X No ss, Give Year Pates: Armed Forces? If Yes 1 Lightest grade completed) 16a. Decedent		Yes 2 X No	specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - White, Specify: W	Mhite		
5-0036 led within 72 hour led within 72 hour lygiene. other than "nature Medical Exau	Elementary/Second	dary (0-12) Colle	ge (1-4 or 5+)	during me	ost of working life. Homemak	ær			Own Home		
215- be filed ntal Hyg rked of	Bornard S	rst, Middle, Last) Shelley Atkir	ıs, Jr.			Bet	Name (First, Middle, F Cty Ann Tho	mas			
D 21 should and Me 7 is man	19a Informant's Name	e/Relationship (Type, Print 5. Atkins - E	Brother	260	South Ma	in St	ber or Rural Route Nun Creet, Keys	ser, WV 2	26726		
of Hea	20a. Method of Dispo	Cremation 3 Remo	uni from State	ematory or otl	ition (Name of cer ner place) S Cemete		9 -1 9 -2 007		City or Town, State		
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr	1 700 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Other Specify: eral Service Licenses disease, or complications t	Day	22. N	lame and Address	onds I	Ambrose Fu Fry Rd., La	neral Ho nsdowne.	ome, Inc. MD 21227		
Physician /Medical kaminer	failure. List only Immediate Cause (Fi or condition resulting Sequentially list cond	one cause on each line. inal disease g in death) Due to (o ditions, nediate Due to (o	hat caused the death. I lications of ras a consequence of)	chronic		11.17	ardiać or respiratory arr	est, shock, or hea	Approximate Interval Between Onset and Death		
_ B G E	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown Other (Specify) Due to (or as a consequence of): Other (Specify)										
Box 68760, e death certificate be the attending physicis of for use as the burish											
P.O.	ŝ	icant conditions contribu	ting to death but not re	sulting in the	underlying cause	given in Pa	23e. Did 1 Ye	es 2 No 3 an 24b. V	bute to the cause of death? Probably 4 Unknown Vere autopsy findings available prior to completion of cause of		
Vital Records, lysician: The law requires this certificate has been significate to age 2 should be					26 Plac	e of Death	perf	ormed? d	leath? ✓ Yes 2 No		
f Vital Rec Physician: The er this certificate ral director, page	1 Yes 2	Hospital:		ER/Outpatien	t 3 DOA	Other4	Nursing Home 5	Residence 6 N			
ivision of V lor Attending Phy after death. Director: After the	27. Manner of Death 1 X Natural 2 Accident	5 Pending	Date of Injury (Month, Day,Year)	28b. Time of	1	Yes 2	No				
Division Division Division Patendial or Attendial ours after death. Ifflied in by the fi	3 Suicide 4 Homicide	determined (Sp.	e. Place of Injury - At ho				or Town,	State)	er or Rural Route Number, City		
To the Hospital within 24 hours. To the Funeral completely filled	_ Z9a. Certiller 1	Certifying Physician: To t Medical Examiner:On the and ma	ne best of my knowledg basis of examination ar nner stated.	e, death occu nd/or investiga	urred at the time, o ation, in my opinio	date and plant on, death or	ace, and due to the cat courred at the time, dat	e and place, and d	lue to the cause(s)		
	29b Signature and t	itle of cotifier	z-Poll	deri		.M.E.		September	r 11, 2007		
70		ess of person who complete nica-Pollak MD. A	ed cause of death (Item ssistant Medical E		111 Penn S	Street, Ba	altimore, MD 212	01			
Sta Registr		ED 1 9 2007	32. Registrar's Signatu	re	refer !						
DHMH 17 Rev 1/200	51	EP 1 0 2001		ORIGIN	AL						

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OCME

		•	For State Registrar	State of Maryland	•	ficate of L		,	Grene Reg. No.	7007	20702	
П	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Dean	
J.	Physici /Medic		Vernon L. Fri	lede1				Sept.	14	2007	2:10a M	
	Examin	er							County of Death			
- 14			Hammonds Lane Cent 5. Social Security Number 6. Sex		st hirthday)	Balti f Under 1 Year	more If Under 24 Hrs.	8. Date of Bir	rth	9 Rintho	lace (State or Foreign	
н	Funeral Director			7. Age (In yrs. las M 2□F 84	Yrs.	lonths Days	Hours Min.	9/4/19	ay, Year)	MD .	itry)	
	-	To Be Completed by Funeral Director	Usual Residence of Decedent					27 1723				
	irylan ihow		10a. State 10b. County	,,	Town or Locati	ion				1	0d. Inside City Limits	
	Ba-f s		MD Anne Arun	del Lin	thicum						1 ∏Yes 2 ∏No	
	3a or 2		10e. Street and Number 117 N. Hammonds Ferry Road			10f. Zip Code 21090				Citizen of What Country? USA		
	death		11. Marital Status	1 X Yes 2 No		Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:			o- 1	an Indian,		
36	be filed within 72 hours after death with the Maryland Hylgiene. I have the than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced						Specify: white			
ğ	2 hou		15. Decedent's Educ	cation	16a. Deceden	t's Usual Occupa	ation	ulaim m	16b. Kin	d of Business/Inc	dustry	
215	thin 7 e. an "n Medi		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			NOT use retired tcher	luring most of wor)	King	meat supplier			
Maryland 21215-0036	ed wi ygien er th t, the		11								er	
n D			17. Father's Name (First, Middle, Last)				18. Mother's Nar					
$\frac{8}{5}$	2 should be and Mental is marked of aumatic ev		John Friedel 19a. Informant's Name/Relationship (Tvi	on Brieft	10h Mailine /	Address (Street		rine Fu		Town, State, Zip	. 0 - 1 - 1	
<u>B</u> a	d 2 sh th and 7 is r traur		Betty L. Friedel,	<i>'</i>	_					cum, Md	-	
ည်	1 an Heal tem 2		20a. Method of Disposition	20b. Pla	ce of Disposition	on (Name of		Date		eation - City or To		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evorce.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ory or other plac	9/1	7/07	Crown	sville,	Md.	
Ħ			21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc, 1630 Edmondson Ave., Catonsville, Md. 21228									
m			Drande Z	Lemmer	/ Fur	neral Ho	me of Ca	tonsvil	le, 1	nc, 163	0 Edmondson	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	Physician /Medical Examiner	in/Medical Examiner	Immediate Cause (Final disease or condition									
1			resulting in death) Due to (o as a consequence of):									
			Sequentially list conditions,	L CROWO	333.4.3						· ·	
a	ted sit		Sequentially list conditions, if any, leading to immediate cause. Ener Unserving Cause (Disease or injury	Due to (or as a consequence of):								
70,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	guence of):								
68760,	s be e											
89	ifficate g phy as the											
Box	h cert andine		IF FEMALE: 23c. If yes, outcome pf pregnancy 1						23d. Date of delivery		егу	
о. П	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	sicis								Month	Month Day Year	
<u>Ч</u>		Completed by Physician/M	9 LI UNKNOWN						Ashana	has an anathibute to the sause of death?		
Ś			2 VM . = 0.0 Cd; 0.1 VM C C Ct d' 0.0									
0.0	requi											
3ec	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director; After this certificate has b completely filled in by the funeral director, page 2 s	ם						24a. Was	s an opsy formed?	24b. Were auto prior to co death?	opsy findings available mpletion of cause of	
a		o Be Con						1□ Yes	2 € No	1 ☐ Yes	2 □ No	
Division or Vital Record			25. Was case referred to medical examiner?	lospital:	D/Outrations	Othe	26. Place of De					
	Physical dispersal dis	I	27. Mann of Death		28b. Time of	3 DOA	4 Nursing I	28d. Describe		Other (Special	(y)	
	th. :: Afte	Medical Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No								
Visi	To the Hospital or Atter within 24 hours after deat To the Funeral Director completely filled in by the		3 Suicide 6 Could not be 4 Homicide determined				28f. Location	28f. Location (Street and Number or Rural Route Numb City or Town, State)		al Route Number,		
Ö			LINGHOUG	building, etc. (opecny)	ng, etc. (Opeciny)					m, oldiej		
	Hospital 24 hours a Funeral I		29a. Certifier (Check only (Check only and manner as stated.) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the H within 24 To the F complete		one)	and manner stated.		29c. License				e signed (Month,		
	N N N	Min.	29b. Signature and title of certifier			_			Zou. Dali	e algited (MOHIN,	Day, Ital)	
			, PU	- wr	>		53467		91	FO121		

State

31. Date filed (Month, Day, Year)
SEP 1 8 2007 MD

32. Rebistrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Road Glen Bornie MD 2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month FER GUSON AUG D. 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore MD Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth Days 1□M 2MF Months 44 Yrs Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. Stete 10c. City, Town or Location 11X Yes 2□ No Baltimore MD 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zin Code 21213 USA 1722 N. Rutland Avenue 14. Race - American Indian, Black, White, etc. African American 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2000 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working unik life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Gloria Barnes Eugene Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 N. Rutland Avenue; Baltimore, Maryland 21213 Darlene Langley / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, Mount Zion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 09/14/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Dent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wterns Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1⊿Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Yes 2 No

Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use es the burial-transit Division of Vital Records, P.O. Box 68760. within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral

Director

Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be nothed at

el Hygiene.

permit. Pages 1 end 2 should be filed.
Depertment of Health end Mentel Hygin Important: If Item 27 ie marked other any injury or other trainment.

Physician /Medical

Examiner

Physician/Medical Examiner

Be Completed by

Medicai Certification: To

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

mis- - 0 Km

filed within 72 hours after deeth with the Marylend

Saltimore, Maryland 21215-0020

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

031885

29d. Date signed (Month, Dev. Year)

2

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

De Care

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBERDALE, 20007 **Physician** 04:45A Guerassio, Sr. Frank J. /Medical 4b. City, Town, or Location of Death 4c. County of Death imore 4a. Facility Name (If not institution, give street and number) Center Examiner If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F Yrs Director 219-14-1953 82 April 16,1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 Dunbar Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 3 Married 1 ☐ Yes 2X No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Years Produce Manager Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pasquale Guerassio ဂ္ Concetta Garbo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Guerassio (Wife) 7001 Dunbar Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o XXBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park 9/15/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Last only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC ADENOCARCINOMA OF LUNG **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perforn Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

The law requires that the death certificate be executed onysician and the burial-transit P.O. Box 68760, ohysician attending ph signed by the a Division or Vital Records, been certificate has I rector, page 2 s or Attending Physician: funeral director, After this after death. the 1 in by within 24 hours a Hospital filled completely

Baltimore, Maryland 21215-0036

Certification: To Medical

4 Homicide 29a. Certifier

6 ☐ Could not be determined

TOWSON, MARYLAND 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number D37254

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE 7601 BOON POH LIM, M.D.

State Registrar



5+1

To the

1 ∰Yes 2 No

Approximate Interval Between Onset and Death

da

Year

1. Decedent's Name (First, Middle, Last) Physician /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Medica Baltimore altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/20/1925. Birthplace (State or Foreign (Month, Day, real) 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 6. Sex Funeral Months Days Hours Min. 220-19-42 Usual Residence of Decedent 1 □ M 2 Ø F Director 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show the Medical Examiner must be notified at Baltimore **Funeral Director** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 0 9 21216 , or Items 23a death v Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 ⊠ f Yes, Give /ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns eny Injury or other traumatic event. It a Media once. College (1-4or 5+) Elementary/Secondary (0-12) 8 64 Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,2//3\,3\,$ 19a. Informant's Na e/Relationship (Type, Print) oes Janice TOWN 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State TOTALSON Forest 9-14-67 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Murch June 21. Signature of Funeral Service Licensee 4300 walrash ave 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) - obstruction ONIC uedo **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicion: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. elevation 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy this certificate 21X No 1 ☐ Yes 2 No within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Medicai

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holly 301 Briam Baltimore 31. Date filed (Month, Day, Year)

State Registrar

2007

Physician /Medical Examiner

Funeral

Plea	se Type or Pri					-		gible.			
For State Registrar		epartment d Sertificate	lental Hygiene 200°			29786					
1. Decedent's Name (First, Middl	le, Last)					2. Date of Death			3. Time of Death		
Eleanor J. Gas						Septem	ber 5,	2007	10:49 PMM		
4a. Facility Name (If not institution	- ,			vn, or Location	of Death		4c. Cour	nty of Death			
Keswick Multi 5. Social Security Number		je (In yrs. last birtho		timore /ear If Unde	r 24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign		
218-18-4017 Usual Residence of Decedent	1□M 2∏F	84 Yrs	Months D	ays Hours	Min.	Jan 2,	y, Year)	Cou	land		
10a. State 10b. County	,	10c. City, Town o	10c. City, Town or Location					10d.			
MD Balti	imore	Ва	Baltimore					1 □ Yes 2			
10e. Street and Number 303 N. Rolling	g Road		10f. Zip Code 21228				10g. Citizen of What Country? USA				
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	in U.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue				- 14. F	14. Race - American Indian,			
1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	li Yes, specily Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify:					Black, White, etc. Specify: white					
15. Deceder	nt's Education est grade completed)	16a. D	ecedent's Usual C	occupation	st of worki	ina	16b. Kind of	ndustry			
Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired) homemaker					own home			
17. Father's Name (First, Middle,	Last)			18. Moth	ner's Name	(First, Middle,	, Maiden Surr	name)			
_Albert G. Karl						M. Ryc					
19a. Informant's Name/Relations William Gaffne	, , , ,		Mailing Address (S					wn, State, Zi	ip Code)		
20a. Method of Disposition	y/son		Winans isposition (Name			re,MD	21229 20c. Locatio	n - City or I	Town State		
1 Burial 2 Cremation	Specify)	camatery	crematory or othe	r place)			200. 2000110	on only or i	own, otate		
21. Signalure of Funeral Selvice	S. Wade Dir	ector	22. Name and A State A Baltimo	natomy	Boar 212	d 655 W	. Balt	imore	Street		
23a. Art1. Enter the disease, o	r complications that cause	d the death. Do not					rrest,		Approximate Interval Between		
Immediat Cause (Final disease or condition		nala	frue	Hea	ital	allu	re		Onset and Death		
resulting in death)	Due to (or as	a cons ence of)	4		-1				The same		
Sequentially hat conditions,	o VA	16006	AN HON	tie	Ste	nosi	5		gen		
Jequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)							U		
that initiated events resulting in death) Last	C. Due to (or as	a consequence of)									
	d										
IF FEMALE:							1				
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)						*					
Part II. Other significant condit	ions contributing to death t	out not resulting in th	ne underlying çaus	se giyen in Part	1.	23e. Did 1	tobacco use c	ontribute to	the cause of death?		
myasthe	nia gr.	Avis,	Desle	tes		10	Yes 2 1	5 3 □ Pro	obably 4 Unknown		
mellelic	, btupe	v tens	ion D	emer	Uza.		psy ormed?	prior to c death?	topsy findings available completion of cause of		
25. Was case referred to medica	al			26. Plac	ce of Deat	1 Yes h (Check only	2 2 No one)	1 □ Yes	2 110		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpa	atient 3 DOA	Other: 4	Tursing Ho	me 5□Resi	idence 6 🗆	Other (Spec	city)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of Inj (Month, Da		ıry	Injury at Work?		28d. Describe how injury occurred					
2 Accident investigation M 1 Yes 2 No Significant No. 1 No. 1 Yes 2 No Significant No. 1 N											
4 ☐ Homicide deterr	nined Zoe, Place of th	tc. (Specify)	i, street, iactory, o	ттсе			Street and Nu wn, State)	imber or Hu	rai Houte Number,		
29a. Certifier 1 Certifyi (Check only one)	ng Physician: To the best I Examiner: On the basis of and manner s	of examination and/	death occurred at or investigation, in	the time, date a my opinion, de	and place, eath occur	and due to the red at the time	cause(s) and , date and pla	d manner as ice, and due	stated. to the cause(s)		
29b. Signature and title of certific	er 1 -	7	29c. L	icense number			29d. Date sig	gned (Month	h, Day, Year)		
> g/ ht	my llil	y, w	Do Do	2520	25		Sept	enbe	6,2007		
30. Name and address of person	who completed cause of	death (Item 23a) (Ty	ype, Print)	Cha	les	J. 1	Balto	· ald	21205		
31. Date filed (Month, Day, Year	32. Regist	rar's Signature	(Carles						.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
SEP]	LO CUUI	Control of the Contro	• /								

State Registrar 07-07171

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 29787 John Steven Grace Certificate of Death 1- For State Rea. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year September 15, 2007 Physician/ 0432 hrs Medical Examiner John Steven Grace 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Baltimore Ramp on outerloop of 695 to 95 North 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. Country) 09/25/1965 Director 212-96-6152 41 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State Yes 2 X No Middle River MD Baltimore Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 610 A Carrollwood Road 21220 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nowith 12. Was Decedent Ever in U.S. Funeral 11 Marital Status more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death withen of Health and Mental Hygiene.
Ant: If item 27 is ingicked other than "natural", or items or other traumatic event, the Medical Examiner must bear If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 2 XMarried Never Married Yes 2 XXNo White Yes 2 X No specify: If Yes, Give Year 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+ Elementary/Secondary (0-12) Truck Driver Transportation 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Finnerty Elaine Richard J. Grace Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 610 A Carrollwood Road, Middle River, MD 2122 ce of Disposition (Name of cemetery, Date 20c. Location - City or Town, State MD 21220 Suzanne M. Grace, Wife 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition timore, crematory or other place) Burial 2 X Cremation 3 Removal from State 09/17/2007 Baltimore, Maryland Bayview Crematory rtant: Donation 5 Other Specify: 22. Name and Address of Facility: 21. Signature of Ineral Service Licensee Skarda Funeral Home M01113 2829 Hudson Street, Baltimore, MD 21224 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List drily one cause on each line. Approximate Interval Physician Between Onset and Death Medical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last P requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial 23d. Date of delivery O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown the ? 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ✓ No 3 Probably 4 Unknown þ Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? The law certificate has Yes 2 No 1 Yes 26 Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Inpatient 2 this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Pedestrian struck by tractor-trailer Certification: FOUND: Yes 2 V No Natural Pending Funeral Director: tely filled in by the Sep 15, 2007 0422 hrs Investigation 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide Ramp to outerloop on 695 to 95 North, Baltimore, MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner states 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tile of September 15, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Susan Hogan MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 200 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O 0 7

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 14, 2007 **Physician** Charlotte May Heath 6:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth May 3, 1928 9. Birthplace (State or Foreign **Funeral** Days Hours 216-22-4438 1 □ M 2 🔀 F Mary Land Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natures" ---- any injury or other trained. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Lansdowne 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Regis Ct. 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Production Line Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard House Cora Welker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Heath/Son 813 Regis Ct. Lansdowne MD 21227 20b. Place of Disposition (Name of Meadlow Tidge Memorial 9-18-2007 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Elkridge MD Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 1. Signature of Funeral Service Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PLLMONALY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No performed Colonaly 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death

1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

> State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only

29b. Signature and title of certifier

KS. DHARMASENA, M.D. 31. Date filed (Month, Day, Year) SFP 1 8 2007

rugue my

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

81.

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE, MO21224

-14-2007

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at be filed within 72 hours after death Baltimore, Maryland 21215-0036 and Mental Hygiene. Is marked other than permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygie Important: If Item 27 is marked other ti any injury or other traumatic event, the once.

Funeral

þ

Physician /Medical Examiner

burial-tran been signed by the attending physician should be detached for use as the buria has been this certificate

Division or Vital Records, P.O. Box 68760 HARTMAN RUTH To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Be Completed 4 □ Donation disease or condition resulting in death) Examiner Physician/Medical IF FEMALE: 9 Unknown Completed by Certification: To Be 1 ☐ Yes 27. Manner of Death 1 Natural

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day,

VISHNU DEEPIKA EVURT

1 8

29a. Certifier (Check only one)

10f. Zip Code 10g. Citizen of What Country? 5202 Talbot Place 21227 United States . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Kraus Elsie A. Link 19a. Informant's Name/Relationship (Type. Print)
Ron Ebaugh - Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Birch Avenue, Arbutus, MD 21227 20a. Method of Disposition

2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Menal Own 1108 & other place) 20c. Location - City or Town, State 5 ☐ Other (Specify) Memorial Park 9-17-2007 | Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. meral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final UROSEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an 2 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

29789

4:30 AM

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

SEP, 14, 2007

week

Maryland

White

Month

Day

14

2007

4c. County of Death

DHMH 17 Rev 1/2001

State Registrar and manner stated.

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P 20998

900 S. Caton Avenue, Baltimore, MD, 21229

State Registrar 29b. Signature and tipe of certifier

31. Date filed (Month

MP

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

MD-21221

09-18-2007.

Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ranklin Square Hospital Rosedale 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) **Funeral** Days 216-24-3858 1 ☐ M 2 ☐ M Director Usual Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Directo Baltimone MD 10e. Street and Number 10f. Zip Code 21206 5626 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Completed by Maggie 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Keeping House 17. Father's Name (First, Middle, Last) Be Mary 2 UNK 19a. Informant's Name/Relationship (Type. Print) +unter 5620 eresa -eiden IUrnen Dave hter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State woodlawn Cen. 20/07 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Hari 1 5126 Road. Belair 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** monary resulting in death) /Medical Due to (or as a consequence of): Examiner neumor Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician and be detached for use as the burial. Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. his certificate has been s I director, page 2 should 24a. Was an autopsy performe After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient ို 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 Homicide the Hospital

1. Decedent's Name (First, Middle, Last) 2. Date of Death Year laggie 2007 15 4c. County of Death Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10d. Inside City Limits 1 TYES 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. African American 16b. Kind of Business/Industry 18. Mother's Name (First, Middle, Maiden Surname) Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hmore MD 21206 20c. Location - City or Town, State Woodlawn 22. Name and Address of Facility Property Service, P.A. Baltimore MD 21206 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 250000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Batto, Md 21237 Kevin mD 000 m. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 18 SEP 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2007

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Florence R. Hall September 15,2007 1:25A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Himore Catous VIII lest NWO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☑ F Director 96 10-9-1910 PA. 216-72-3044 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic everance. 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Baltimore MD Catonsville 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 719 Maiden Choice Lane BR420 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: white ğ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mazie Meckley George Mosebrook ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1827, Sykesville, Md. 21784 19a. Informant's Name/Relationship (Type. Print) Glen E. Hall, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Paurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cem. 9/20/07 Baltimore, Md. 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licenses Funeral Home of Catonsville Inc, 1630 Edmondson Ave., Catonsville, Md. 21228 Dand Lemme 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerati Cardiac **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 2 4 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ၉ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 = ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who compled cause of death (Item 23a) (Type, Print) Maiden Baltinore MD 21228 Lane 32 Registrar's Signature 31. Date filed (Month Day, Year) State Registrar

DHMH 17 Rev 1/2001

		•	1 - State of Marylar State of Marylar Registrar		rtificate of De			eg. No. 200	7 29793
ř.	Physicia		1. Decedent's Name (First, Middle, Last) Vivian M.	How	e11		2. Date of Deat Month Septem	ber 11, 20	3. Time of Death 2:09 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of De	ath
- 1			8209 Thornton Road		Tows			Balti	
	Funeral Director			. last birthday) 30 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August	, Year) (irthplace (State or Foreign Country) Ohio
	and w t		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notlfled at	tor	Maryland Baltimore	Towso	n				1 □Yes 2 💢 No
	r 28a	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What (Country?
	th with		8209 Thornton Road		21204			U.S.A	١.
	r dea	Funeral	11. Mantal Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	eanic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Specify:		Specify:	lhite
2	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of worki	ing	16b. Kind of Busines	ss/Industry
2	within ene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		utive Secr			Steel C	Company
о О	filed Hygid Sther Sent, tl		17. Father's Name (First, Middle, Last)	LACC			(First, Middle, i	Maiden Surname)	ompany
au	고 호 호 호	To Be	Frank Buffo			J	osephin	e Fa	sciani
ary		_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and				, Zip Code)
			Christine Burroughs Niece		Coastland				95125
altimore,	of H H		20a. Method of Disposition 20b. 1 □ Burial 2 ▼ Cremation 3 □ Removal from State	Place of Dispo cemetery, crei	sition (Name of matory or other place)	С	Date	20c. Location - City	•
Ē	Pages tment of tant; If it tant; or o		4 □ Donation 5 □ Other (Specify)	the second secon	ervice Cor		-2007	Towson	Maryland
Bal	permit. Pag Department Important: any Injury o		21. Sgrature When Service Licensee		2. Name and Address 1050 York			on Funeral Maryland	Home, Inc. 21204
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ent	ter the mode of dying,	such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	toge	Renal	Discon	-		Onset and Death
ja.	/Medical Examiner		resulting in death) Due to (or as a conse	quence of):					20 415
5	Lxammer	_	Sequentially list conditions, b.	ension					20 500
1	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	M	ellity				10 years
<u> </u>	ificate be executed g physician and as the burial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
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-	tificat ng phy as th	fedi							
Box	death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fel		∃Ectopic pregnancy			23d. Date of o	delivery Day Year
o.	The law requires that the death cert ite has been signed by the attending agge 2 should be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	death 5	Other (specify)			Nona	Day Tour
Vital Records, P.	s that ned b e deta	by Pł	Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause given	in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ğ	w requires that s been signed to should be deta						1 □ Y	es 2⊠XNo 3∏	Probably 4 ☐ Unknown
ပ္ပ	law re as bee	Completed					24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
œ.		No.					perfor	med? death	
<u>ita</u>	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of Deatl	,		
	Physi rthis c ral dire	70	1 ☐ Yes 2 ☑ Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatier 28b. Time o		4 ☐ Nursing Ho		ence 6 Other (Si	pecify)
Ę	ding F	ion	1 Natural 5 Pending (Month, Day Year)	Injury	Work?	es 2 🗆 No	Zou. Describe n	ow injury occurred	
Jivision or	ten lor: the	fical	3 Suicide 6 Could not be determined 28e. Place of injury - At I	nome, farm, str			28f. Location (S	treet and Number or	Rural Route Number,
	al or /	Certification:	4 Homicide determined building, etc. (Spec	ify)			City or Tow	n, State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my kn and manner stated.						
	To the within To the	Me	29b. Signature and title of certifier		29c. License r	number	2	29d. Date signed (Mo	onth, Day, Year)
}			MD MD		03	1016		Sente mse	- 13, 200t
~	20		30. Name and address of person who completed cause of death (Ite Kenneth M. Green, M. 6701	m 23a) (Type, N. C.	Print) evice St. Sc	. Je 4105,	15. Hh	an 'no	~ 13, 2007 21204
	Sta Registr		31. Date filed (Month, Day, Year) SEP 18 2007 32. Registrar's Sign	nature	andi)				

	Physician
	/Medical
	Examiner
1	

Funeral

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division or Vital Records, P.O. Box 68760,

-	For State Registrar	Certif	icate of L	Death	Re	eg. No. 200	29794				
n	1. Decedent's Name (First, Middle, Last)				Date of Deati Month	Day Year	3. Time of Death				
	EDWARD LOUIS HOEN				SEPT.	9 2007	11:00a ^M				
r	4a. Facility Name (If not institution, give street and number) 13908 FOUNTAIN RD.	(OCEAN (4c. County of Dea	'ER				
	5. Social Security Number 6. Sex 7. Age (<i>In yrs. Ia</i> 213−28−1487		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/24/	^{(Yea} r) 30 MAR	thplace (State or Foreign ountry) YLAND				
	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	on				10d. Inside City Limits				
<u>ه</u>		IMONIT					1 □Yes 21No				
<u> </u>	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What Co	ountry?				
	16 CULMORE COURT		210	93	USA						
Funeral Director	11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 □ No	. 13. Was	Decedent of Hi es, specify Cuba	spanic Ongin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi					
2	1 □ Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Dates:	1 🗆	1 ☐ Yes 2 MANO Specify: WHITE								
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind	's Usual Occupa d of work done o NOT use retired	luring most of worki	16b. Kind of Business/Industry						
E O	Elementary/Secondary (0-12) College (1-4or 5+) 4YRS •	SALES	SMAN			SALES					
Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name		•					
0	RALPH HOEN			MABEI	L STANT	ON					
	19a. Informant's Name/Relationship (Type. Print)					; City or Town, State,	_ ′				
	DOTTIE HOEN(WIFE)	16 CT	JLMORE		MONIUM,						
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	metery, cremate	ory or other plac	e)		20c. Location - City of HYDES,	·				
	21. Signature of Euroral Service Lices	HE		JENKINS			1.				
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Onset and Death Onset and Death										
	resulting in death) Due to (or as a consequence)	ence of):	0				2:0				
_	if any leading to immediate Due to (or as a consequence of):										
Jine	Secue tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence or):									
Examiner	that initiated events c	ence of):									
	d										
edical	0.	2.21									
M/UE	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal		topic pregnancy	,		23d. Date of de					
Completed by Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ther (specify) _			Month	Day Year				
y Ph	Part II. Other significant conditions contributing to death but not result	Iting in the unde	rlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?				
ed p	MYPERLIFERENT REMOVE PIECE	06050	7,		1 🗆 Y	es 2□No 3□F	robably 4. Inknown				
plet	CEPRETION				24a. Was a	24b. Were a	utopsy findings available completion of cause of				
E O					autops perfor 1∐ Yes	med?// death?	s 2□No				
Be	25. Was case referred to medical examiner?		Loth	26. Place of Deat							
0	T res 2 no 1 inpatient 2 l	28b. Time of	3 DOA Oth	4 Linuising no		ence 6 Other (Sp ow injury occurred	ecity)				
tion	1 □ Natural 5 □ Pending (Month, Day Year)	Injury	28c. Injur Wor M 1 □	k? Yes 2∐No	200. Beschibe in	ow injury occurred					
fica	3 Suicide 6 Could not be 28e. Place of injury - At hor	Rural Route Number,									
Serti	4 Homicide determined building, etc. (Specify	,			City or Tow	n, State)					
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner systed.	vledge, death or ion and/or inves	ccurred at the til stigation, in my o	me, date and place, opinion, death occur	and due to the or rred at the time, o	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)				
Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mor					
	I will n	1095	<	HT. 11, 3	2007						
	30. Name and address of person who ompleted cause of death (Item ERIC CARR M.D. 12221 TULL)	23a) (Type, Pri		MONIUM,	MD. 210	093.					
te	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ure Angel	0								
ar	SEP 1 8 2007 Season 18	No. of the last									

State Registrar

1 Decedent's Name (First, Middle, Last) 2. Date of Death 15,2007 **Physician** SEPT. ANNIE M. HANCOCK 1:25M P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. Cify, Town, or Location of Death **Examiner** 435 N. CURLEY ST. BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG . 14, 1951 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 223 80 5978 56 VIRGÍNIA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 435 N. CURLEY ST. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOUSEKEEPING KENILWORTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLEVELAND BAKER CORNELIA HANCOCK ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA TAYLOR (daughter) 435 N. CURLEY ST. BALTO, MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation GREEN MOUNT CREMATSRY. 19,2007 BALTIMORE, MD. 3 Removal from State 4 ponation 5 ☐ Other (Specify) mature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME Emadene V 1412 F PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the distribution of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 hec **Physician** ancer head disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has lirector, page 2 autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 Norm Broadway, Bulhmore MD 21231 Mic 31. Date filed (Month, Day, R gistrar's Signature State g Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07157 State of Maryland / Department of Health and Mental Hygiene Arnita Howell 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 14, 2007 1936 hrs Medical Examiner N 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 2323 Maryland Avenue Apt. 3C 9. Birthplace (State or 7. Age (in yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** oreign Months Hours Director 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No 28a-f show items 23a or 28a-f shoust be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Race - American Indian, Black, 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 2 X No Yes 9 Yes 2 No specify: Specify: (Divorced If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

fant: If item 27 is marked other than "naturall",
or other trainmatic event, the Medical Examiner ۵. 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Itimore, X Burial 2 Cremation 3 Donation 5 Other Specify: 22. Name and Address of Far 21. Signature of Funeral Service Licensee Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Physician een Onset and failure. List only one cause on each line. Medical Death a. Diabetic ketoacidosis Immediate Cause (Final disease xaminer Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Acords, r.c. Los Certificate be executed
The law requires that the death certificate be executed and Physician/Medical AMENDED #23a,27,perME,g873, 11/14/07 TT X UNPENDED attending physician or use as the burial -Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown q Unknown the 8 signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Completed by Yes 2 V No 3 Probably 4 Records, P. 24b. Were autopsy findings available peen : 24a. Was an prior to completion of cause of autopsy After this certificate has performed? death? funeral director, page 2 No 2 Νo ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other₄ Residence 6 V Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide

within 24 hours after death.

To the Funeral Director: completely filled in by the Medical

29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME September 15, 2007 Ollivie 30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registra

31. Date filed (Month, Day Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Brazel September 14,2007 Boone Henslev 2:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 602 Wayneleaf Court Harford Edgewood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 08/17/1928 1**X** M 2□ F Months 403-32-2243 79 Ohio Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show must be notified at Harford Edgewood 1 ☐Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 Wayneleaf Court 21040 United States "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No White Specify ò Specify: 3 XWidowed 4 ☐ Divorced Year or Dates Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shelby Boone Hensley Polly Anne Gregory ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Wayne Hensley, Son 602 Wayneleaf Court, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 09/18/2007 Baltimore, Maryland 4 Donation 5 Dher (Specify) 21. Signature of Funeral 22. Name and Address of Facility M01113 Thomas J. Skarda Funeral Home 2829 Hudson Street, Baltimore, MD 21224 23a. Part1. Enter the dis shock, or heart fail ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1. es 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has e 2 autopsy performed? Yes 2 page certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 40 Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) ို this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 31. Date filed (Month, Day, Year) . Registrar's Signature SEP 1 8 2007 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner:

Medical

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien ?

29798 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician September 4:55 P.M 16, 2007 Helen Mae Isensee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll Long View Nursing Home Manchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XXF 87 Yrs Director 220-10-0904 25, Maryland 1920 Apr. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "nature!", or Items 23a and 10 marked other than "nature!". 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State XX Yes 2 No Directo Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citized of What Country? United States 4010 Doefield Drive 21102 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 22 Moo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2XNo Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Agnes Patterson James Taylor ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 Doefield Drive; Manchester, Maryland 21102 <u> Karen L. Schaefer (Daughter)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Sep. 20, 20a Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Pikesville, Maryland Druid Ridge Cemetery 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service License 3296 Charmil Drive; Manchester, Maryland 21102 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final askinsonism **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the i 9 Unknown 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Be Completed peen Was an autopsy performed?
Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an certificate 1 ☐ Yes To the Hospital or Attending Physicien: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident Iniun 5 Pending investigation 1 Tes 2 No within 24 hours after deave.
To the Funeral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 51705 of death (Ithm 23a) (Type, Print) , Hestminston, MD 21157. PANSURIYA 349 malwim 31. Date filed (Month, Day, Year) State 1 8 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Jesus Platas Iglesia	1- For State	Maryland / Depa <i>Cer</i>	rtment of tificate of		ental Hygiene	20 (7 2979	
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Jesus	Ig1	lesias		2. Date of D Month Septem		3. Time of Death 1331 hrs	
<i>(</i>	4a. Facility Name (if not institution, give s Suburban Hospital	treet and number)	4	o. City, Town, or Locati Bethesda	ion of Death	4c. County of Dear Montgomery	h	
Funeral Director	5. Social Security Number 6. Sex 231–02–2980 1 X	7. Age (In yrs. Ia	ast birthday) Yrs.		ours Min	Birth (MM/DD/YYYY) 9. B Fore C	rthplace (State or gn ountry) Spain	
d fow any	Usual Residence of Decedent 10a. State 10b. County D • C •	10c. City,	Town or Location			70 2, 1742	10d. Inside City Limits 1 X Yes 2 No	
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 4517 Western Aven		Washing	10f. Zip Code 20016		10g. Citizen of What Co	untry?	
ath w items ist be	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced If 15. Decedent's Education (Specify only	r Dates:	1 X	s, specify Cuban, M ex	Origin? (Specify Yes or ican, Puerto Rican, etc.) cify: Spanish Sive kind of work done	No- 14. Race - Ame White, etc.	rican Indian, Black, iite /Industry	
5-0036 Ited within 72 hour Hygiene. I other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)		y Driver	NOT use retired)	Embassy o	of Spain	
21215-(21216) and be filed IMental Hygis is marked oth ic event, the TO Be Co	Nicanor Iglesia: 19a. Informant's Name/Relationship (Typ		19b. Mailing	V	incenta Pla	·	te, Zip Code)	
Z gg and Z m	Alicia Iglesias , 20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	Place of Disposi crematory or oth	tion (Name of cemeter) er place)	September		or Town, State	
Baltimore, permit. Pages I at Department of Hee Important: If ite	Donation 5 Other Specify: 21. Signature of Funeral Service License	e	22.N Rob	en Cemetery ame and Address of Fa ert A. Pumphr 7 Wisconsin A	19, 2007 rey Funeral Hor	ne/Bethesda-Cho	cing, Maryland	
Physician Medical xaminer	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Friter Underlying Councilloses or injury that initiated co.	ations that caused the death line. ead Injuries ue to (or as a consequence of the to (or as a consequence of the to (or as a consequence of	of):			arrest, shook, or heart	Approximate Interval Between Onset and Death	
0, be executed sician and ourial - transi	d. UNPENDED	AMENDED						
. Box 68760, in the death certificate be executed by the attending physician and ached for use as the burial - transit Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fet	al death 3 Ec	ctopic pregnancy	23d. Date of deliver	Day Year	
P.O. es that the igned by be detach	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause given	1 24a. W		autopsy findings available o completion of cause of	
of Vital Records, ng Physician: The law requir ther this certificate has been in meral director, page 2 should 1 n: To Be Completed	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	spital: 1 Inpatient 2 🗸	28b. Time of I	3 DOA Othe	Training Floring	ibe how injury occurred	ner:	
Division o Division o spital or Attending tours after death. filled in by the func Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - At h		1 ✓ Yes :	ng, etc. 28f. Location	on (Street and Number or I n, State) n Lane NW, Washingt		
To the Hosp within 24 ho To the Fune completely f	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: C	a: To the best of my knowled on the basis of examination a nd manner stated.	ige, death occur and/or investigat	red at the time, date ar ion, in my opinion, dea 29c. License nur	th occurred at the time, d	cause(s) and manner as state and place, and due to 29d. Date signed (A	the cause(s)	
		mpleted cause of death (Item	n 23a)	O.C.M.E. September 16, 2007				
State Registrar	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature							

Physician/ Il Examiner	4	Decedent's Name (First, Middl	lo Lost)					Reg.	NO.	<u> </u>	
		Jessica	a Meredi					Date of Death Month September		3. Time of Death 1938 hrs	
		a. Facility Name (if not institution Sinai Hospital				Baltimore	or Location of Death		4c. County of Dea	Α	
Funeral Director	2	Social Security Number 214-90-6044	6. Sex	7. Age (In yrs. Ia	est birthday) Yrs.	If Under 1 Ye		_	Fore	ountrille (State of Sign Country West Virgi	
low any	1	Isual Residence of Decedent 0a. State 10b. County Md. Balt	imore	1 "	Town or Locati					10d. Inside City Limits 1 Yes 2 X No	
the Maryland or 28a-f show ifted at once. Director		0e. Street and Number 1904 Cranbot				10f. Zip Code	21093	10g	Citizen of What Co	· ·	
2 should be filed within 72 hours after death with the Maryland hand Mental Hygies Mental Hygies 77 is marked other than "natural", or items 23a or 28a-f atter matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1		Armed		If Y	es, specify Cub	dispanic Ongin? (S an, Mexican, Puerto		White, etc.	erican Indian, Black,	
72 hours after "natural", al Examiner eted by	⋧┝	3 X'Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Deceden during m	ost of working li	pation (Give kind of ife. DO NOT use ret	ired)	6b. Kind of Busines	s/Industry	
tiled within 12 hour il Hygiene. ed other than "natu t, the Medi al Exan		7. Father's Name (First, Middle John Mere	e, Last)	-4	Acco	untant/		nager e (First, Middle, Ma in Owen	Financia (iden Surname)	al .	
I and 2 should be filed with Health and Mental Hygiene, item 27 is marked other th r traumatic event, the Med To Be Com!	ם ו ס	9a. Informant's Name/Relation Mr. John Merec	ship (Type, Print)	her			reet and Number or	Rural Route Numb	er, City or Town, Sta		
ss I and of Healt If item her trau		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other S	on 3 Remova	I from State	Place of Dispos crematory or of aney Va	ner place)		Date 19-07	20c. Location - City Timoni ul		
permit Page Department Important: injury or oth	1	21. Signature of Fundal Salvice	e Licensee			1050	ess of Facility Towson F York Rd.	LOWSON.	Ma. 71704	Approximate Interval	
ysician Medical caminer		23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line. e a. <mark>Gunshot</mark>	wounds (2) of	torso	ne mode or dyn	ig, such as caldiac	or respiratory arres	n, diods, di licari	Between Onset and Death	
ed nsit	niner	Sequentially list conditions, if any, leading to immediate course. E. tsr Ur Jarrying Coust (Disease or injury that initiated Course).									
		events resulting in death) Last	d. AMENDE	as a consequence of	of):						
ath certificate be attending physicis or use as the buri	sician/I	IF FEMALE: (3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✓ U	the 23c. If your 1 Liv	es, outcome of preg we birth regnant at time of do nknown	2 F	etal death ther (Specify)	3 Ectopic pregr	nancy	23d. Date of delive Month	very Day Year	
uires that the n signed by the Id be detached	ক্র	Part II. Other significant cond	ditions contribution	ng to death but not i	resulting in the	underlying caus	se given in Part I.		2 No 3 F	e to the cause of death? Probably 4 Unknown e autopsy findings available	
The law requir	Completed							autops perform 1 V Yes 2	y prior med? death	to completion of cause of	
hysician: The raths certificate al director, page	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2		t 3 DOA		sing Home 5 1	Residence 6 O	ther:	
Attending Ph death retor: After toy the funeral	Certification:		ending Sep	Date of Injury Indian Day Year) 14, 2007 Place of Injury - At h	28b. Time of UNKNOW	N 1	Injury at Work? Yes 2 ✓ No	Subject shot		r Rural Route Number, City	
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		4 Homicide de 29a. Certifier	termined (Spec	cify) Single Fa	mily			or Town, St 1904 Cranbou		ville Timonium, MD	
To the Hospital within 24 hours a To the Funeral I completely filled	edica	(Check only one) 2 ✓ Medical Ex	xaminer: On the ba and mann	sis of examination	and/or investig	ation, in my opir	nion, death occurred	d at the time, date a	and place, and due t	o the cause(s)	
		Journal 30. Name and address of pers	Dell on who completed	cause of death (Ite	m 23a)	0.	.C.M.E.		September 15	5, 2007	
W		Tasha Greenberg M		t Medical Exar		Penn Stre	et, Baltimore, N	MD 21201			

07-07159 Jeffrey Carl Jacobsen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 29801

sincy Can bacc.	1	I- For State Certificate of Registrar	f Death	, , ,	Reg. N	Z U (
Physicia	n/	1. Decedent's Name (First, Middle,Last) JEFFREY CARL JACOBSEN			Date of Death Month Da September 1	y Year	3. Time of Death 1912 hrs	
ledical Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		September 1	4c. County of Death	i i	
Europel		1904 Cranbourne 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Inder 24Hrs.	8. Date of Birth(N	/M/DD/YYYY) g. Bir	thplace (State or	
Funeral Director		221-40-8074 XM 2 F 38 YR			MAY 26	Foreig	ountry) DE	
on war and a		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion			,	10d. Inside City Limits	
	_	SC HORRY MYRTLE BE	EACH				1 Yes 2 X No	
after death with the Maryland al", or items 23a or 28a-f show ner must be notified at once.	Director	10e. Street and Number 9633 SCALLOP COURT	10f. Zip Code 29572	2	10g.	Citizen of What Cou	intry?	
with t	- 1	Tr. Waltar States	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the White, etc.					
r death or ite	Funeral	Never Married 2A Married 1 Yes 2 X No	Yes 2X No spe			Specify: WH]	TE	
2 5 6	9	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry						
. 4	Completed	Flementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO N $\mathbf{AGEMENT}$	NOT use retire		COMPUTE	RS	
5-0036 led within 72 tygiene other than		17. Father's Name (First, Middle, Last)			First, Middle, Mai			
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	o Be	REGINALD H. JACOBSEN 19a. Informant's Name/Relationship (Type, Print). 19b. Mailin	ng Address (Street and		TURNE		e, Zip Code)	
MD 2 MD 2 id 2 shoul ifth and M m 27 is n aumatic	۲	REGINALD H. JACOBSEN father 963	33 SCALLOR	P CT.	MYRTLE	BEACH S	SC 29572	
Baltimore, MD 2 bernit: Pages I and 2 shou Oepartiment of Health and I Important: If iten 27 is n injury or other traumatic		1 Burial 2 X Cremation 3 Removal from State GREEN MO	osition (Name of cemeter) other place) OUNT		1	BALTIM		
		4 Donation 5 Other Specify:	Name and Address of Fa	acility HEN	JRÝ W.	JENKINS	& SONS CO	
Ball permit Depart Impor injury		(IN ONACO	16924 YORF	K RD N	MONKTON	, MD 21	L 1 1 Approximate Interval	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	. 1-	as cardiac or	respiratory arrest	, shock, or near	Between Onset and Death	
caminer		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):		140				
		Sequentially list conditions, b.					-	
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					4	
recuted and transit	I Examine	events resulting in death) Last Due to (or as a consequence of): d.		·				
760, cate be exec physician a	Medical	UNPENDED AMENDED				Les British	-	
Division of Vital Records, P.O. Box 68760, — To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 E	ctopic pregna	ncy	23d. Date of deliver	Day Year	
BOy e death the atte	hysi	1 Yes 2 No 9 Unknown g Unknown		in Port I	23e Did tob	acco use contribute	to the cause of death?	
P.O. that the med by detach			e undenying cause given	i III Pait I.			robably 4 Unknown	
ds, Fequires	Completed by				24a. Was ar	24b. Were	autopsy findings available o completion of cause of	
e law r e has b ge 2 sh	mpl				perform	ned? death	?	
II RE	a)	25. Was case referred to medical		Death (Check	only one)		Page—d	
Vita hysicia this ce	To B	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			3	Residence 6 V Ottoow injury occurred	ner: Scene	
n of ding P h. After funera		27. Manner of Death 1 Natural 5 Pending FOUND: 28a. Date of Injury FOUND: FOUND: FOUND: FOUND: 10007		2 ✓ No	Subject shot			
ivisior f or Attend after death Director:	Certification:	2 Accident Suicide 6 Could not be	treet, factory, office buildi	ing, etc.			Rural Route Number, City	
Div ospital or hours aft meral Di	ertil	3 ✓ Suicide 6 Could not be determined (Specify) Single Family				ate) ne Road, Lutherv		
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t			curred at the time, date a gation, in my opinion, dea	and place, and ath occurred a	I due to the cause at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)	
To the within: To the comple	Medical	and manner stated. 29b. Signature and title of certifier	29c. License nu			29d. Date signed (
		Joinh Jeep nos	O.C.M.E	Ξ.		September 15, 2007		
15		30. Name and address of person who completed cause of death (Item 23a)	11 Penn Street, Ba	ltimore MI	D 21201			
\			11 Penn Street, Ba					
S	tate	CED 1 8 2007	ALCOHOL SON					

			State of Maryland / Department of Health and Mental 1 - For State Registrar Certificate of Death	Hygiene Reg. No 2007	29802
100	Physici	an	1. Decedent's Name (First, Middle, Last) DEBORAH JONES 2. Date of Month	h Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2 2007 4c. County of Death	1235 A M
	Funeral Director		216 50 0601 12 X 58 YIS. Apr	th, Day, Year) Coun	lace (State or Foreign try) RYIJAND
	ow ow	9.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		0d. Inside City Limits
	e Man Ba-f sh ntifled	ctor	MD. N/A BALTIMORE		1√Yes 2□No
	a or 2	I Dire	10e. Street and Number	10g. Citizen of What Coun	itry?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director		or No- c.) 14. Race - Americ Black, White,	etc.
21215-0036	within 72 hou iene. than "natura the Medical Es	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Ind	
d 21	filed w Hygier other th	o Cor	5 10TH WELDER 17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Name (<i>First, Middle, Last</i>)	WELDING (Middle, Maiden Surname)	co.
ylan	should be nd Mental marked c	To Be	o Un known PEARL JO		
Maryland	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type. Print) BRYANT JONES (son) 19b. Mailing Address (Street and Number or Rural Route No. 19b. Mailing Address (Street		Code)
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition 1 □ Disposition 1 □ Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY CEMETERY SEPT. 20, 2	20c. Location - City or To	
Balti	permit. Departr Imports any Inji		21. Agriculture of Funeral Service Licensee CALVIN B. SCRUGGS FT	BYLLO WD 5.	1213
39	Physician	3.	23a. Part1. Enter the disease, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause of each line.	tory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions b.		mens
8760,	ate be executed ohysician and the burial-transit	ical	<u>d</u>		
P.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delive	ery Day Year
	law requires that the de as been signed by the . 2 should be detached	by	a at it. Other significant conditions contributing to death portion resoluting in the underlying cause given in Fatty.	. Did tobacco use contribute to the	ne cause of death?
Il Records,	The lar ate has page 2	Completed	24a.	autopsy prior to con performed? death?	psy findings available mpletion of cause of 2 No
Vita	Physician: The rithis certificate ral director, pag	Be	25. Was case referred to medical examiner?		
n or	ng Phy (fter this ineral c	on: To		Residence 6 Other (Specification of the control of	y)
Division or Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined Suicide 4 Homicide Accident investigation M 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	ation (Street and Number or Rura or Town, State)	al Route Number,
	e Hospital 24 hours a Funeral etely filled	Medical Co		to the cause(s) and manner as setime, date and place, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number D 25344	29d. Date signed (Month,	Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 1 Aman 2011 Haymmonds Fe	ing Rel 2	nr
	Sta Regist		e 31. Date filed (Month, Day, Year) 32. Restrar's Signature		
			The state of the s		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of N	viaryian		artment of F rtificate of a		, ,	eg. No. 200	7 20803
1	Dhysisi	4	1. Decedent's Name	e (First, Middle, L	.ast)					2. Date of Dea Month	th Day Year	3. Time of Beath
	Physicia /Medic		Mary Eliz	abeth John	ston					Sept 12,		8:45 A M
7	Examin	er	4a. Facility Name (II	f not institution, g	ive street and numbe	er)		4b. City, Town, o	r Location of Death	1	4c. County of De	
	4,	30	703 S. Ch	erry Grove		#103	last birthday)	Annapo	is If Under 24 Hrs.	8. Date of Birth	Anne Aruno	
	Funeral Director		291-07-50	52	Sex 7. / 1 □ M 2 □ X	92	Vre	Months Days	Hours Min.	(Month, Day	, rear)	irthplace (State or Foreign Country) OHTO
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at	_	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2\1\1\1\1\1\1\n
	ne Ma 8a-f s	Director	FL	Palm Beac	h	Lal	ke Worth	7				
	vith the	Dire	10e. Street and Nur	mber				10f. Zip Code		1	0g. Citizen of What C	ountry?
	sath v s 23a nust	eral		Park Driv	e West 12. Was Deceder	nt Ever in II	6 12	33/467	lianania Origina (Cr	nonify Van ay Na	USA 14. Race - Am	orinan Indian
	ter de item	Funeral	11. Marital Status 1 □ Never Marri	ied 2□ Married	Armed Forces	s?	.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	Black, Wh	
920	urs al al', or Exam	by	3 X Widowed		1 □ Yes 2 If If Yes, Give Year or Dates	S:		1⊡Yes 2√√ No	Specify:		Specify:	White
2-0	72 ho natur lical l	ited	(Spec	15. Decedent's l	Education	,,,	16a. Dece	dent's Usual Occup	ation during most of wor	kina	16b. Kind of Busines	s/Industry
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Seco		College (1-4o	or 5+)	life.	DO NOT use retired	1)	King		
2	filed with Hygiene. ther than		12 17 Father's Name ((Final Middle La	-4)		I R	estaurant (no /Firet Middle	Cook Maiden Surname)	
and	2 should be filed and Mental Hygi is marked other aumatic event, t	Be	17. Father's Name (•	31)					, ,	waiden Surname)	
Ž	2 should and Mer is marke aumatic	۵.	George Joh 19a. Informant's Na		(Type Print)		19h Mailii	ng Address (Street	Mary Lic		r, City or Town, State,	Zin Code)
Ma	and 2 sealth an n 27 is ier trau		James P	·	Son			•				, ,
<u>ත</u>	s 1 and 2 f Health ttem 27 other tr	1	20a. Method of Disp		3011	20b. P	lace of Dispo	Sition (Name of matory or other place	1	<u>کی Annapol</u> Date	is, MD 2140 20c. Location - City of	1 r Town, State
Baltimore,	Page ment o ant: If ury or			☐Cremation 3. 5 ☐ Other (Spec	Removal from Stat	te	Ι.	-	i i	17 2007	Royal Palm	Danah El
altii	permit. F Departm Importar any Injur		21. Signature Fy		ense	Quee		Name and Addre			Koyai Pain	weach, FL
ä	Depa Impo any I		K. Great	ory Fink	M01148			426 Crain F	wy S, Glen	M. Burnie, M	D 21061	
i,			23a. Part1. Inter the shock, or hea	he dis ase or c	milications that caus ne cause on each	ed the death	h. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory arr	est,	Approximate Interval Between
-4	Physician		Immediate Cause ((Final	•	0	0-		Dece		ure-	Onset and Death
	/Medical Examiner		resulting in death)		Due to (or a	as a consequ	uence of):		1			
	Examiner	_	Sequentially list con	nditions,	b		iana eti					
	led issit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	erlying Injury	Due to for a	as a conse 』	uence of i:					1
m	xecut and al-trar	хап	that initiated events resulting in death) L	Last	c Due to (or a	as a consequ	uence of):			7.		
68760,	ificate be executed g physician and as the burial-transit			•	d							
68	ificate g phy as the	edical			u.							
Вох	eath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcon			∃Ectopic pregnancy			23d. Date of d	elivery
	ne deatl the atte	sicia	in the past 12 1 ☐ Yes 2 ☐	2\u00e4\u00e	4□Pregnant 9□Unknown	at time of de		Other (specify)	/		Month	Day Year
P.0	at the d by the stached	hys	9 ☐ Unknown									
<u>S, I</u>	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other signif	licant conditions	contributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
Vital Records,	requ been	Completed										02-35-0
3ec	ne law has t ye 2 s	du								24a. Was a autops perfor	sv prior to	autopsy findings available o completion of cause of
a	ician: The certificate ha ector, page									1□ Yes	2 No 1 □ Ye	es 2/2 No
Κ		Be	25. Was case referrexaminer?		Hospital: 1 □ Inpa	tiont 0 🗆	ER/Outpatier	nt 3 DOA Oth	ar:	th (Check only or	1 4 1	ON'S Apartmen
O	Physer this eral di	2	27. Manner of Deat		28a. Date of Ir	njury	28b. Time o	IL 3 L DOA	4 □ Nursing H	ome 5 Resident	ence 6 Other (Sc ow injury occurred	ecity) V
ion	nding I th. ; After e funer	ţi	1 Natural 2 ☐ Accident	5 ☐ Pending investigati		Day Year)	Injury		k? Yes 2 ∐ No			
Division or	Atter	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	be d 28e. Place of i	injury - At ho	ome, farm, str	eet, factory, office		28f. Location (S. City or Tow.	treet and Number or I	Rural Route Number,
O	ital or rs afte al Dir led in	Certification:			Dallally,	- (Opeon)			9	Only of Ton	n, olaloj	
	Hosp 4 hou Fune ely fil	Medical	29a. Certifier (Check only one)			of examina					ause(s) and manner added	
	To the I	Me	29b. Signature and	title of certifier	? /	12	12	29c. Licens	e number	, 2	9d. Date signed (Mo	nth, Day, Year)
		ł	1	1	2//	00	-	1	15/5	5/	Spotom	ben 13, 200)
	/		30. Name and addr	ess of person wh	o completed cause of	f death (Item	1 23a) (Type,	Print)	1	1/	01	Q /2
	6		31. Date filed (Mon		L DEL	strar's Signa	1.O_	305	705A1	tof ()	INA Gen	Drum [d. 406)
	Sta Registr		SE	p 1 8 20	107	Car Solida	500		0		/	

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland / Depa	artment of H	lealth and N		ene2007 a. No.	29804	
	16		Decedent's Name (First, Middle, Landson Communication)	ist)				2. Date of Death		3. Time of Death	
	Physici		Nancy Lee Chalk	Jeffries				Septembe	Pay Year 200	7 1:40 P ^M	
7	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death		4c. County of Death		
			2516 Pleasantvil	le Road			ston		Harf	ord	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Ag 1 ☐ M 2X F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)	
	Director		213-30-6509 Usual Residence of Decedent		75 Yrs.			Jan. 19,	1932 M	aryland	
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits	
	Mary F-1 sh	tor	Maryland Harf	ford	Fal.	lston				1 ☐ Yes 2½ No	
	n the	Director	10e. Street and Number	.O	101	10f. Zip Code		10	g. Citizen of What C	ountry?	
	death with the Maryland me 23a or 28a-f show I must be notified at		2516 Pleasantvi	lle Road		210	147		USA		
	or dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
9	hours after turel', or ite al Examine	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	No	1 ☐ Yes 🎎 ☐ No	Specify:		Specify:	val. i.e.	
9500-61212	hour		15. Decedent's E	J	16a, Dece	dent's Usual Occupa	ation	1	6b. Kind of Business	White Undustry	
<u>ე</u>	within 72 ene. then "na	Completed	(Specify only highest gi	rade completed) College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of world	king		,	
7	d with giene	E O	12	College (1-401)		Homemak	er		Own Hom	e	
yland	be ilied within 72 hours after death with the Marylan lat Hygiene. Id other then "natural", or iteme 23a or 28a-1 show event, the Medical Examinat must be mutiled at	Be (17. Father's Name (First, Middle, Las	t)				e (First, Middle, M			
<u>X</u>		10	Frank (unk) Chal					May Stei			
Mar	d 2 should th and Mer ?7 is marke treumatic	8 3	19a. Informant's Name/Relationship						City or Town, State,		
o,	1 an Heal Heal		William Jeffrie 20a. Method of Disposition	s / Son	2510 20b. Place of Dispo		tville Ro		ston, MD oc. Location - City o		
פַ	Pages nent of int: If it		1.X Burial 2 □ Cremation 3		cemetery, cre	matory or other plac	-	1			
Baitimor	교육환경 .		4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lice		Jessops	Cemetery Name and Address	ss of Facility	3-07	Sparks, M	aryland	
n n	Depa Impo eny li		Russell Ch		1	Name and Address MCCOMAS FI	uneral Ho	me, P.A.	D 21014		
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused	the death. Do not en	on W. Browner the mode of dyin	g, such as cardiac	or respiratory arres	D 21014	Approximate Interval Between	
,	Physician	. 1	tmmediate Cause (Final disease or condition	One cause on each	ZHEIN	IFR'S	DEN	EUTIA	_	Onset and Death	
	/Medical		resulting in death)	a Due to (or as	a consequence of):	, ,	20.0	70 7 7 7		(TEXT	
	Examiner	_	Sequentially list conditions	b							
-	pg is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
2/00,	icate be executed physicien and s the burial-transit	aiE		200							
מל	ate hy	edicai		d							
žo	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7			23d. Date of de	alivery	
	death	sicia	in the past 12 months?	4☐Pregnant at		□Ectopic pregnancy □ Other (specify)			Month	Day Year	
j.	that the de	hys	9 DUnknown								
S,	rw requires that the s been signed by th should be detache	þ	Part II. Other significant conditions	contributing to death b		inderlying cause give	en in Part I.		. /	o the cause of death? Probably 4 Unknown	
coras,	requi	sted	Tion	1212 100	. 070			1 🗆 Yes			
ဗို	The law ate has b	Completed						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of	
<u>a</u>								1 ☐ Yes 2	1 ☐ Ye	s 2 No	
VITAI	Attending Physician: r death. ector: After this certific by the funeral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Othe		th (Check only one	nce 6 ⊡Other <i>(Sp</i>		
ō	ding Phys h. After this funeral dir	-	27. Manner of Death	28a. Date of Inju (Month, Da				28d. Describe how		9Crry)	
<u> </u>	tending feath. tor: Aft the fun	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injury		Yes 2 □No				
UIVISION	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place of III	jury - At home, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,	
5	ital or its aft rai Di	Cer									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	ı miner: On the basis o	of my knowladge deal f examination and/or in	h occurred at the time exestigation, in my o	ne data and clane pinion, death occu	and due to the oar rred at the time, da	te and place, and du	e to the cause(s)	
	thin 2 the mplet	Med	onei	and manner et	ated						
1	S 7 8 7		Ins	ntol. V	Mari	DO	01638	7 5	EPTEMA	ER 13,2007	
	C		30. Name and address of person who	completed cause of o	leath (Item 23a) (Type	Print)				21047	
	7		PER FECTO	C. VALA	PRAD H.	01716	HAR FOR	DRd Su	1.105 PM	MISTON MA	
	Sta	te	30. Name and address of person who all titled (Month, Day, Year)	32 Registr	rar's Signature	2037 3					
	Registr	ar	SEP 1 8 2	UUI JUNE	www. My						

DHMH 17 Rev 1/2001

		For State	State of M	aryland / Depa	artment of I rtificate of			0.0	00~	0000
8	10	Registrar 1. Decedent's Name (First, Middle,	Last)	06	illicate of	Dealli	2. Date of De	Reg. No.	IUT	3. Time of Death
Physic /Medi		Halv	or M. Jui	ıl, Jr.			Septem	ber 14,	2007	3:05 AM
Exami		4a. Facility Name (If not institution,	give street and number)			or Location of Death	1	4c. Coun	ty of Death	1
		Wilson Health 5. Social Security Number 6		ne (In vrs. last birthdav)	Gaith	ersburg	8. Date of Bir		tgome	
Funeral Director		346-22-1942	1 <u>M</u> M 2□F	78 Yrs.	Months Days		(Month, Da	iy, Year) 1, 1929	Cou	pplace <i>(Stat</i> e or Foreign Intry) Lnois
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		-			10d. Inside City Limits
Mary I-f sho fled a	tor	Maryland Montgo	mery	Potomac						1 ∐Yes 2 X No
th the or 28g e noti	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ıntry?
ath wi 23a ust b	ral	11748 Gainsboro			208			United	Stat	tes
er deg Items ner m	nue	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.))- 14. Ra	ace - Amen ack, White	ican Indian, , etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 AYes 2 ☐ If Yes, Give Year or Dates:	Korea	1 ☐ Yes 2 💹 No	Specify:		Spec	ify: W	hite
d 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	ted	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occu	pation	king	16b. Kind of I	Business/II	ndustry SOCiation
ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) _	_	e during most of wor ed)	KITIY	Of Real		SOCIALION
illed w Hygiel ther th	Co	17. Father's Name (First, Middle, La	5+	Lcon	omist	18. Mother's Nan	ne /First Middle	Maiden Surna	(me)	
d be i entai ked o	To Be	Halvor M. Juu					ma Voge		ine,	
shou and M s mar umati	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Stree	t and Number or Ru			n, State, Zi	ip Code)
and 2 salth a 27 k		Kirsten M. Juul	/ Daughter	13059	Old Ann	apolis Ro	oad, Mt.	Airy,	Mary	land 21771
permit. Pages 1 a Department of Hez mportant: If Item my injury or othe ince.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3	□Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	sept	Date ember	20c. Location	- City or T	Town, State
t. Pag tment tant:		4 □ Donation 5 □ Other (Spe	ecify)	Montgomery			2007	Bethe	sda, l	Maryland
permil Depar Impor any ir once,		21. Signature of Funday Service Li		M01305	2. Name and Addr bert A. Pu	ess of Facility Imphrey Fune	ral Home/	Rockvill	e, <u>I</u> nc	d 20850–2805
		23a. Part 1. Enter the disease, or coshock, or heart failure. List or	,						aryl <i>a</i> n	Approximate
Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	.1	i .						Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence of):		· · · · · · · · · · · · · · · · · · ·				y rav
Examiner		Sequentially list conditions.	b. Pa	rhingun)	direa	u				Veans
ped sit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						/
executed and al-transit		that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
e be e	cal E		L _d .							
Physician: The law requires that the death certificate be ethis certificate has been signed by the attending physician ral director, page 2 should be detached for use as the buring	Completed by Physician/Medical	IF FEMALE:								
eath cert attending for use a	ian/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	∃Ectopic pregnand				ate of deliv	very Day Y ear
he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9⊡Unknown	t time of death 5	Other (specify) _			"	norta i	Day You
es that the de igned by the be detached	/ Ph	Part II. Other significant condition	s contributing to death b	out not resulting in the u	nderlying cause gi	iven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
w requires been sign should be	q p	deculitu	ulus				1 🗆	Yes 2 No	3☐ Pro	obably 4 □Unknov
aw requ s been 2 shoule	olete						24a. Was	an 24b	. Were aut	topsy findings availat
The law ate has page 2 s	mo						auto perfe 1□ Yes	ormed? 2 No	prior to co death? 1 ☐ Yes	ompletion of cause o 2 ☐ No
sician: The law requires the certificate has been signe rector, page 2 should be continued.	Be (25. Was case referred to medical examiner?				26. Place of Dea		- '		
Physic this c	2	1 ☐ Yes 2 D M6	Hospital:		II 3 DOA		lome 5 Res			cify)
l or Attending Physafter death. Director: After this in by the funeral di	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Da	ay Year) 28b. Time o	Wo	uryat ork?]Yes 2 □No	28a. Describe	how injury occu	urred	
Atten deatl	fical	3 Suicide 6 Could no		jury - At home, farm, st tc. (Specify)			28f. Location (Street and Nun	nber or Ru	ral Route Number,
s after	Certification:	4 ☐ Homicide determin	building, e	tc. (Specify)			City or To	wn, State)		,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical (29a. Certifier i Certifying (Check only one)	Physician: To the best xaminer: On the basis of	of examination and/or ir	h occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	cause(s) and r	manner as e, and due	stated. to the cause(s)
thin 2 the complete	Med	29b. Signature and title of certifier	and manner st	rated.	29c. Licen	nse number	-1	29d. Date sign	ned (Month	n Day Yearl
F 3 F 8			n 1 - 1	5				_ou. Date orgi	(101011111	, -w, , cur/

State

30. Name and address of person who control of the state o

ppleted cause of death (tern 23a) (Type, Print)

29. Degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Knold EtER 00:57 AM September 2007 13 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Baltimone Hospital Johns Hopkins City N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1**X** M 2□ F Yrs 60 CT 057-36-4050 May 1 1947 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Washington Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 548 21719 USA 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Contractor Industrial Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Knold Ivan Rosemary Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Besket - sister 530 Penny Lane, Cockeysville, 21030 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 9/14/2007 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams ²²Chame and Address of Facility of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Negative GRAM Sepsis 2weeks resulting in death) Due to (or as e consequence of): 6wecks Hopatic Abcc 55 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

physician and s the burial-transil

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signed by the al

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director,

has page 2

certificate

this

Director: After the

death.

within 24 hours after To the Funerel Direct

completely filled

Medicai

Hospitel

the

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The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Physician

/Medical

Examiner

Directo

Completed by Funeral

Be

2

Funeral

Director

27 is marked other than "netural", or Items 23a or 286-f show treumatic event, the Medical Examinar must be notified at

Hygiene.

item 27 is marked of

ō <u>=</u> 6

permit. Page Department of Importent: If any injury or once.

other

Pages 1 and 2 should

the Maryland

with

deeth

be filed within 72 hours after

Baltimore, Maryland 21215-0036

ner Certification:

Exami Completed by Physician/Medical Be 2

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 Yes 2 No 3 Probably 4 Unknown

23e. Did tobacco use contribute to the cause of death?

autopsy performed? Yes 22 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

25. Was case referred to medical examiner? 2 No 1 🗌 Yes 27. Manner of Death

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

and manner stated

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No М Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 Suicide

4 Thomicide

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certified Scott Construtt medical Docton

2007

6 ☐ Could not be

determined

RES-000

September 13,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and Scott C. Mathenly
31. Date filed (Month, Day, Year)
CFP 1 8 Johns Hopkins Hospital, 620 North Wolfe Street, Baltimone, Maryland 21287

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HOLLY BENNETT KENT 13 2007 EPTEHBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE CITY N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🕏 F 551-74-6184 Director 11/25/1955 VIRGINIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE NOTTINGHAM 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with # Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Expenses nust be no once. 9022 FIELDCHAT ROAD 21236-1813 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Completed by Specify. 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 YEARS ADMINISTRATIVE ASSISTANT UNIVERSITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ JAMES W. BENNETT RITA C. WEBBER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT W. KENT/HUSBAND 9022 FIELDCHAT ROAD NOTTINGHAM. MD 21236-1813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 9/18/2007 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee LOCH RAVEN BLVD. TOWSON. MD 21286 Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ULMUNAR **Physician** Day /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as e consequence of). Il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and 1 in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral Completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SEPTEMBER, 132007 aguna

State Registrar 31. Date filed (Month, Day, Year) SEP 1 8

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omil

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 1:50 PM Orville Jay Kauffman 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Oct. 31, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 200-24-1084 Pennsylvania Director 1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or? 21030 10316 Greenside Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒No Completed by Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 5+ Chemical Engineer Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy H. Kauffman Janet Ellen McCormick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn C. Kauffman wife 10316 Greenside Drive; Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Ite any injury or of once. 1 X Burial 2 Cremation 3 Removal from State 4 □ Dona 5 ☐ Other (Specify) Dulaney Valley Mem Gardens: 9/20/07 Timonium, MD uneral Se vice/Licer 22. Name and Address of Facility 21. Signature 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ongestive 7 days resulting in death) /Medical Due to (or an consequence of): Examiner lobe UWLV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Acute Rend Division or Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of i Director: After to in by the funera 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aff

To the Funeral D

completely filled in 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063163 September 15, 2007

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State Registrar 31. Date filed (Month, Day, Year)

201 East University Parkway



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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07-07162 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Qasim Kabah 2007 29809 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year September 15, 2007 0001 hrs Qasim Khan Ka'Bah Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 2526 Terra Firma Road **Baltimore** n/a 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** preian Months Davs Hours Min Director 215-96-4370 1 X M 2 F Country) Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Baltimore filed within 72 hours after death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21225 USA 2526 TerraFirma Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 01. Yes 2 X No African-American . 4 If Yes. Give Year Yes 2 X No specify: Specific Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) he Medical 12th Landscaper Baltimore City permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. t: If item 27 is marked other other traumatic event, the Me 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oist Ka'Bah Patricia A. McKinney Be 2121 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S Patricia A. Ka'Bah/ Mother 2526 TerraFirma Rd., Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) XBurial _2 Cremation 3 Removal from State 9-19-07 Glen Burnie, MD mportant: Cedar Hill Cemetery nation 5 Other Specify rature of Funeral Service Licen 22. Name and Address of Facility Wile F/ II P.A. of Balto. Grunty 9200 Liberty Rd., Randallstown, MD 21133 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Midical Death a. Stab Wound to Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED by the attending physician sched for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Precnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? o. contributing to death but not resulting in the underlying cause given in Part I ģ Yes 2 ✓ No 3 Probably 4 Unknown ے Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 2 No ✓ Yes 2 No 1 V Yes 26 Place of Death (Check only one 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Innatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 2 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject stabbed FOLIND: Division Natural Yes 2 V No Pending within 24 hours after death To the Funeral Director: the Sep 14, 2007 2351 hrs 2 Accident Investigation in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2526 Terra Firma Road, Baltimore, MD determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. September 15, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 MARLER. Registra

State of Marvland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Kimble 13, 2007 2:32 A M Wayne Harman September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12020 Suffolk Terrace Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1X M 2□ F 49 1958 West Virginia 224-90-5145 March 3, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. The Modern France. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland| Montgomery Gaithersburg 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 12020 Suffolk Terrace United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) Of Health Maintenance Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Donald Brown Kimble Geraldine Shreve ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Kimble / Wife 12020 Suffolk Terrace, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 17, 2007 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 17 Months **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the period transition than the property. Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 2□ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MID D53317 September 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 16220 Frederick Road, Suite 213, Gaithersburg, Maryland 20877 Joseph A. Ball, M.D. 31. Date filed (Month, Day, Year) 8 32. Registrar's Signature State 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Q Year **Physician** ALFRED KLOTZMAN 07 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital at N/A Date of Birth (Month, Day, Year) 07/30/1921 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Funeral 1**X** M 2□ F Months Days Hours Min Yrs. 86 215-14-0857 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f shormust be notified at 1 ☐ Yes 2 No Director BALTIMORE PIKESVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8004 IVY LANE 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify: WHITE Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be KLOTZMAN BENJAMIN LILLIAN DIAMOND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra once. 8004 IVY LANE, FRANCES KLOTZMAN / WIFE PIKESVILLE, MD 21208 20b. Place of Disposition (Name of ANSHEER HANNEY PROPERTY OF STREET PROPERTY OF STREET PROPERTY OF STREET PROPERTY OF STREET PROPERTY OF STREET PROPERTY OF STREET PROPERTY OF STREET PROPERTY OF STREET PROPERTY OF STREET 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 09/16/2007 | BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service L SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Dur o (or as a conseque of) Examiner Sequentially list conditions Due to or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 Tyes 2 Accident 2 ∏ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

The law requires that the death certificate be executed use as the burial-trar Division or Vital Records, P.O. Box 68760, attending physician for sate has been signed by the page 2 should be detached Hospital or Attending Physician: fureral director. A Br 24 hours af er death Funeral Director: filled in by within 24 hou To the Fune completely fi To the l

death with

Baltimore, Maryland 21215-0036

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items 23a

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

146 CH 340 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Year)

AMAMO UA

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Kichara 9 2607 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randal (stocen Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Fore Country) **Funeral** Months Min unk 1 ₹ M 2 □ F Feb 13, Director 66 213-36-2940 1941 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1√2 Yes 2 □ No ns 23a or 28a-f sh must be notifled MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 337 S. Stricker Street or items 23a 21223 USA Funeral 12. Was Decedent Ever in U.Sunk Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ρ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk un 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If item 27 any Injury or other tra 21133 9109 Liberty Road Randallstown, MD Genesis Randallstown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □ Removal from State 4□Donation 5▶Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street S. Wade, Director Rona Id Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner monary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ongestive The law requires that the death certificate be executed Heav and burial-tran Due or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 10 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 17 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Hospital or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and itle of certifie 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a),(Type, Print) 30. Name and ad person who con lonth, Day, State 18 SEP Registrar

DHMH 17 Rev 1/2001

			For State Registrar	ate of Marylan		artment of H rtificate of L		ental Hygien Reg. N	71111	29813
	Physici		1. Decedent's Name (First, Middle, Last) SAUL LIENF	ELD				2. Date of Death Month DEFTEMBER	bay th Year	3. Time of Death 5. \5 A M
	Examir		4a. Facility Name (If not institution, give street NORTHWEST HOSPITAL	and number)		_	Location of Death		c. County of Deatl	h
-	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs.	last birthday)	If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth	9. Birtl	hplace (State or Foreign
4	Director		216-46-6362 1 M 2 Usual Residence of Decedent	□ F 59	Yrs.	Months Days	Hours Min.	01/16/194	8	MD
	/land low at		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD BALTIMORE		BALT	IMORE				1 ☐ Yes 2 No
	ith the	Jire	10e. Street and Number			10f. Zip Code	-	10g. C	Citizen of What Co	untry?
	s 23a	eral	7243 BROOKFALLS TERR				1209			SA
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Me Meal Examiner must be notified at	by Funeral Director	1 Never Married Amarried 1.	as Decedent Ever in U. med Forces?] Yes 2 \ No ∕es, Give ar or Dates;		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗖 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: W	
2-0	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade com	oleted)	(Give	dent's Usual Occupa	turing most of working	16b.	Kind of Business/I	ndustry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)		DO NOT use retired FIED PUBL	.IC ACCOUN	TANT	STATE (OF MARYLAND
	Hygid Other ent. th	Be Co	17. Father's Name (First, Middle, Last)	•	<u> </u>	. 125 , 052	18. Mother's Name (OT THREE PRINTS
Maryland	should be and Mental marked o	To B	ABRAHAM		LILIE	NFELD	LORRAIN	Ξ		ZEMIL
lan	2 sho and f Is ma		19a. Informant's Name/Relationship (Type. Pr	int)			and Number or Rural			ip Code)
e, ≤	1 and 2 Health em 27		LINDA LILIENFELD / W	IFE land		BROOKFAL sition (Name of	LS TERRACE			21209
nor	Pages nent of h ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	SESTINO	NTEFFORE	ONG 09/17	/2007 PA	Location - City or T	
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licensee	- WO	22	2. Name and Address	s of Facility SOI	LEVINSO	N & BROS	., INC.
26	00 = 00		23a Part1. Enter the disease or complication	s that caused the death			TERSTOWN I		KESVILLE	, MD 21208 Approximate
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final						-0	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	1,1000	KWE V	HEIL HEIL	CUT 21	CAD_
	Examiner		Sequentially list conditions, b.							
<i>y</i> .	ned nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (of as a consequ	Jerice of):					
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. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	res, outcome pf pregna □Live birth 2 □ Feta □Pregnant at time of d	I déath 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.O.	at the I by th stache	Phys	9 LJ UNKNOWN	JUnknown						
Division or Vital Records,	w requires that been signed to should be det	ρλ	Part II. Other significant conditions contributions 1144 PERTEIN SIDIN	ng to death but not rest	liting in the ur	nderlying cause give	en in Part I.			the cause of death? bably 4 Unknown
O	aw req	olete	DIRBETES	MEHITINS				24a. Was an	24b. Were au	topsy findings available
æ		Completed				·-		autopsy performed? 1☐ Yes 2 1 N	death?	ompletion of cause of 2 X No
/ita	cian: ertifica ector,	Be	25. Was case referred to medical examiner?				26. Place of Death (-		- -
or o	Physic this c	은	1 ☐ Yes 2 No Hospita	li: 1 Inpatient 2 ☐	ER/Outpatien 28b. Time of		4 LI Nursing Home	5 Residence		eify)
UO	tending Physician: The leath. tor: After this certificate hathe funeral director, page	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	rat ?? Yes 2∐No	d. Describe how inj	ury occurred	
Visi	after death Director: /	Certification:	a Could not be	Place of injury - At ho building, etc. (Specify				f. Location (Street a	and Number or Ru	ral Route Number,
Ö	Ital or rs afte ral Dir	Cert	4 Tromode	City or Town, Sta	ue)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Physician 2 Medical Examiner: Call Medical Exam	To the best of my kno n the basis of examina nd manner stated.	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	ne, date and place, ar pinion, death occurred	d due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	m - Ala	m.t	29c. License			ate signed (Month	n, Day, Year)
			XXX			- 4	1410		TEMBER 1	11/2017
	20		30. Name and address of person who complete	ed cause of death (Item	23a) (Type,	Print) Tobin	WER P. 5	ALHIN	9117	2
	Sta	te	31. Date filed (Month, Day, Year)	32 legistrar's Signa	TER ture	KAN	DAUSTON	AM WIL	5 2113	٠ <u>ر ر</u>
	Registr	-	SEP 1 8 2007	32 legistrar's Signa	X AM	W.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fb 9871 9-28-07 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NATHANIEL MANUEL SEPTEMBER14, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL CENTER NIA RALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Sex 1M 2□F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 152-30-9306 66 Director VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 XYes 2 No Director MARY/AUD 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "yay injury or other traumatic event, the Mecone. College (1-4or 5+) Elementary/Secondary (0-12) 6 HIGRADE ONSTRUCTION WORKER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be SEORGE XOL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANUEL ASCENSION IZABETH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Deensee Fart1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory armst, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final sease or condition resulting in death) HEPATIC PORTAL HYPERTENSION Physician /Medical Due to (or as a consequence of): Examiner 1 YEAR ANEMIA Sequentially list conditions, Directo for es a consecuence offi Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHRONIC OBSTRUCTIVE PULMONARY DISEASE 20 YEARS physician and the burial-tran Due to (or as a consequence of): 30 YEARS Physician/Medical ALCOHOLISM IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

law requires that the death certificate be executed Division for Vital Records, Fo the Hospital or

P.O. Box 68760

Baltimore, Maryland 21215-0036

David Press State Registrar

31. Date filed (Month, Day, Year) SEP 18 2007

cim. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and fittle of certifier

m.D. 32 Registrar's Signature

3001 SOUTH HANOVER STREET

RES 001

JEPTEMBER 15, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year McMillan thony 0130 eptember 12 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A Momorial Baltimore Union Hospital 9. Birthplace (State or Foreign Country) D A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Days Hours 1 M 2 □ F PA 168.36.015 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Baltmore 1 XYes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Street 21218 35th 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) State of MD Elementary/Secondary (0-12) Correctional Officer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McMillan Kuth Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21218 35Th Street Thoma McMillan 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dwings Mills, MD 1XBurial 2 ☐ Cremation 3 ☐ Removal from State Garnson Forest 09/19/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Srvs 21. Signature of Funeral Service Licensee 4905 York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 days Intracranial Due to (or as a consequence of) pertension or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | → nknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No 24a. Was an autopsy performed 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and the attending physician hed for use as the burial Division or Vital Records, P.O. Box 68760. page 2 should be detached completely filled in by the funeral death. 24 hours after death e Funeral Director;

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Examiner

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Be 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 1 ☑Natural 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

within 2

31. Date filed (Month, Day,

Union

Memorial Hospita

MO who completed cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

2007

arold Thomas N	1		oartment of ertificate of		d Mental Hy		3. No. 20	07 2981
Physicia	ın/	Decedent's Name (First, Middle,Last)				Date of Death Month	Day Year	3. Time of Death 1616 hrs
ledical Exami		Harold Thomas Magers, Jr.		L Other Target and	Landing of Dooth	Month September	13, 2007 4c. County of Deat	
		4a. Facility Name (if not institution, give street and number) Howard County General Hospital	4	Columbia	Location of Death		Howard	-34
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year		. 8. Date of Birth	n(MM/DD/YYYY) 9. Bi Forei	rthplace (State or
Director		220-88-3965 1x M 2 F	40 Yrs.	Months Days	Hours Min.	Sept.	21,1966 ^c	ountry) MD
		Usual Residence of Decedent	ity, Town or Location					10d. Inside City Limits
w an			Jessu					1 Yes 2 X No
Aaryland 28a-f show any 1 at once.	후	MD Howard 10e. Street and Number	bessu	10f. Zip Code		110	g. Citizen of What Cou	
th the Maryland 23a or 28a-f sho notified at once	Director	8039 Lincoln Drive		207	794	10.5	U.S.A.	,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Metrial Hygiene. 27 is marked other than "naturial", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in	1 U.S. 13. Was		spanic Origin? (Sp	pecify Yes or No-		rican Indian, Black,
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hours		15. Decedent's Education (Specify only highest grade completed			tion (Give kind of v . DO NOT use reti		16b. Kind of Business	/Industry
36 in 72 han " tical 1	Bet	Elementary/Secondary (0-12) College (1-4 or 5+)	Sche	duler		ā	Steel C	orn
5-0036 led within 72 tygiene. other than '	Completed	17. Father's Name (First, Middle, Last)	Deric		18.Mother's Name	(First, Middle, M		orp.
21215-0036 21215-0036 puld be filed within 72 Mental Hygiene. marked other than ic event, the Medical	Be (Harold T. Magers, Sr.				yn Davy		
21 hould. Is mai		19a. Informant's Name/Relationship (Type, Print)					ber, City or Town, Stat	e, Zip Code)
mad 2 sho leath and tem 27 is traumati		Donna Magers (Wife) 20a. Method of Disposition	b. Place of Disposi	Lincoln		Jessup,	MD 20794 20c. Location - City of	r Town State
7		1 X Burial 2 Cremation 3 X Removal from State	crematory or oth	ner place)				**
Baltimore, permit Pages I al Department of He Important: If ite			Farley Ce				Flat Lick	
Baltimo permit Page Department Important: injury or oth		21. Supplure of Funeral Lery et boerse	283 5	555 Twin	Knolls	.tzke rui Road Co	neral Home olumbia,MD	s, Inc. 21045
Physician		23a. Part I. Enter the disease, or complications that caused the de	ath. Do not enter th	ne mode of dying,	such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical	9 15	failure. List only of e cause on each line. Immediate Cause (Firth disease a Occlusive Pulmonary)	y thromboemb	olis		4		Death
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led led	Examiner	events resulting in death) Last Due to (or as a consequence	ce of):					
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Box 6876 e death certificate the attending phy ed for use as the	Physician/M	past 12 months? 1 Live birth Pregnant at time of	f -1 11-	tal death 3 her (Specify)	Ectopic pregn	ancy	Month	Day Teal
Box death death d for u	ıysi	1 Yes 2 No 9 Unknown g Unknown		1101 (000011)				
P.O. Box 6876 ss that the death certificate gned by the attending phy e detached for use as the b	by Pł	Part II. Other significant conditions contributing to death but n	ot resulting in the u	underlying cause	given in Part I.		bacco use contribute	to the cause of death? Obably 4 Unknown
ords, P.C. w requires that as been signed I	ed b					24a. Was		autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir is after cleath. "I Director: After this certificate has been seled in by the funeral director, page 2 should I	Completed			· ·		autop		completion of cause of
Rec The Is	Com	No. 111				1 🗸 Yes		
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inactions 2	Eno Latin		e of Death (Check		Residence 6 Ott	nor-
f Vi Physi er this	2	1 Yes 2 No Inpatient 2 27. Manner of Death 28a. Date of Injury	✓ ER/Outpatient 28b. Time of I		ury at Work?	28d. Describe	how injury occurred	
on of nding Pl th. :: After	ion:	1 Natural 5 Pending Aug 26, 2007	1000 hrs		Yes 2 ✓ No	Subject inju	red knées while p	olaying soft ball
risic r Atte er dea irector	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - 28e.	At home, farm, stre	et, factory, office	building, etc.			Rural Route Number, City
Division of Nospital or Attending Phyours after death. meral Director: After t	Certification:	3 Suicide 6 Could not be determined (Specify) Soft bal	I field			or Town, S Unknown, ,	state)	
		29a. Certifier (Check only 1 Certifying Physician: To the best of my know	vledge, death occur	rred at the time, d	late and place, an	d due to the caus	se(s) and manner as st	ated.
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or investiga	29c. Licen		at the time, trate	29d. Date signed (A	
	Σ	29b. Signature and title of certifier			.M.E.		September 14,	
		,	itom 22a)				1	
10		30. Name and address of person who completed cause of death (Ling Li, MD Assistant Medical Examiner	item 23a) 111 Penn Stree	et, Baltimore,	MD 21201			
0 -	tate	31. Date filed (Month, Day, Year) 32. Resistrar's Sig	gnature	rock				
Regis			S A	Mark Contraction				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9 19 4 / 20 87 12:50P M Regina Mia Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2501 Banger Street Baltimore n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🛛 F 216-54-4125 Director 58 3/4/1949 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 XYes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2501 Banger Street 23a 21230 USA Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10 \end{array}$ College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If Item 27 Is marked o any injury or other traumatic eve Eugene Capelli Dorothy Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Banger Street, Baltimore, MD 21230 Bernard Martin / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9/18/2007 Baltimore, MD 21. Ignature of Funeral Service Licen 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Physician/Medical as attending use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 18 months? Month 4□Pregnant at time of death 5 Other (specify) led by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s prior to compledeath? autopsy perfor 1∏ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only offe Other: 4 Nursing Home 1 TYes 5 Residence 6 □Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Peat

1 ★ Natural

2 ★ Accident 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation filled in by the fu 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

To the Hospital or Attending Physician: within 24 hours a

> State Registrar

29b. Signature and title of certifier

30. Name and address of person -FONE 31. Date filed (Month, 'Day," Year, 29c. License number

and manner stated

		-	For State of Maryla		artment of He rtificate of D			eg. No 2007	7 29818
	Dhuninin		1. Decedent's Name (First, Middle, Last)						3. Time of Death
	Physicia /Medic	_	Raymond Do	Raymond Douglas Mathena, Jr			SEPTEM.		vo7 1:45 pm
	Examin	-	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death		
	- A Company of the Company		Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In)	ro. Inothirthday		More City		N/A	Birthplace (State or Foreign
	Funeral Director		218-26-4109 XXM 2□F 77	rs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 16,	Year) 1930 No	Country) ew Jersey
	and w	-	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryle f shored at	Director	Maryland Baltimore	**		Dundal	.k		1 □Yes 2% No
	the rate		10e. Street and Number		10f. Zip Code		10	0g. Citizen of What	Country?
	h with		204 North Branch Road		21222	2		United	States
	ems :	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W	merican Indian,
330	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	ک ک	1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 22 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:	, ,	Specify:	White
2-003p	72 hou natura lical E	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done do	tion	ina	16b. Kind of Busine	ss/Industry
7	ithin he.	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	`life. L	DO NOT use retired)		9		T
7	lled w Hygier her ti nt, the		11 Years 17. Father's Name (First, Middle, Last)	Ste	eel worke	18. Mother's Name	First Middle A		Industry
and	2 should be filed within and Mental Hygiene. s marked other than "amatic event, the Mec						Vorrelle	naideir Surname)	
Ξ	should nd Me mark matic		Raymond D. Mathena, Sr. 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a			City or Town, State	e, Zip Code)
Z	nd 2 s alth ar 27 is r trau		Lois Louse Mathena (Wife)		4 North B				and 21222
ē,	s 1 a		Zou: Metrica of Bioposition	b. Place of Dispo cemetery, crer	sition (Name of matory or other place	9)	Date :	20c. Location - City	or Town, State
ē E	Page nent c ant: If ary or		1 ABurial 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 □ Other (Specify)		ll Mem. G		5/2007	Middle R	iver, MD
pair	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Judy al Service Incensor	/// D	Name and Address	Funeral 1	Home of	Dundalk,	Inc.
ı		\Box	23a Part. Enter the disease, or complications that caused the c		7922 Wise er the mode of dying				Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	21.0	a se di	DMY	0474		Onset and Death
1	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions b. Due to APP APTERY DISEASE 30 Years.						7 01-75
	Examiner		Sequentially list conditions b. O.	Y ARTERY DI		D151	SEASE 30 Yea		
/	po #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):					U
V	and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C	sequence of):	quence of):				
Š	be ey	edical	230 10 (10) 220 230 (10)						
08/PN	ficate be physicia s the bur		d						
XOD	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pre		Testania programana			23d. Date of	delivery
-	death e atten	Physician/M	in the past 12 months? 1 Yes 2 No 1 Yes 2 No					Month Day Year	
J Ö	w requires that the dibeen signed by the should be detached	h	9 LJ Unknown	117 1 11		/ D) /	00 - Bid t-t		
Ś,	res th	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
ecords,	requi	Completed					138	550	
9	2 2 2	du					24a. Was ai autops perforr	y prior	autopsy findings available to completion of cause of
a	n: The ficate har, page		OF Was area veteral to medical				1□ Yes 2	2 X (No 1 □ Y	
VITal	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No Hospital: 1 Inpatient	 2 □ ER/Outpatier	ot 3 DOA Othe	26. Place of Deat		<i>e)</i> ence 6 □Other (S	Speciful .
0	iding Physician: th. After this certifica	<u>⊢</u>	27. Manner of Death 28a. Date of Injury	28b. Time o				w injury occurred	респу)
0	ath. r: Afte	atio	1 Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	r) Injury		es 2□No			
DIVISION	or Atter ter des nirecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp	At home, farm, str	reet, factory, office		28f. Location (St. City or Town		Rural Route Number,
	pital c ours af eral D	ဦ	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	29a. Certifier 1 or the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	vithin To th comp	Me	29b. Signature and title of certifier		29c. License			9d. Date signed (Me	
			I Chyul ms		00	0201	11 5	ENTOMB	ER 12,2007
	15		30. Name and address of person who completed cause of death ((Item 23a) (Type,	Print) mul	SI HO	SPITAL	7112000	SE 12,2007
	Sta	e	31. Date filed (Month, Day, Year) \$2. Registrar's S	ignature	01.0.	0100	77 17 7	11 MICWY	,03/0
	ા ગાત			E a	AMERICA.				

Registrar

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygien Certificate of Death 29820 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1:45 **Physician** September Donald 13,2007 Jesse /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster
If Under 1 Year | If Under 24 Hrs. | 8. Carroll Hospice Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F AUJUST 18, 1977 30 Maryland Director 214-98-6724 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner roust be notified at 1 ☐ Yes 2 No Director Maryland Carrol Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 1001 21158 USA Taneytown Pike itama 23a Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deet Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural". or Item any injury or other traumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) System School Janitor 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vada Viola Carbaugh May Sc. Robert Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 Taneytown Pike Westminster, MD 21158 Mother Vada May 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Anatomy Gifts Registry September 13,2007 Hanover, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Lios need 1522 Connelley Drive Suite P. Harover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LIVEN disease 4 days Decompensated Physician /Medical Due to (or as a consequence of): Examiner Alcohol induced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes the Hospital or Attending Phyeiclan; 26. Place of Death Check onl one Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatrent 3 ☐ DOA 1 | Yes 2 | No P 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO Moch D 52035 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO ZIIS7 291 Westminster Stones BINU CHACKS 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 1 8 2007 Registrar

			1 - State of Maryland / Dep	partment of Health and Mertificate of Death	1ental Hygien Reg. N	2007 29821			
е	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ruth Dora Miller		2. Date of Death Month Sept. 1	3. Time of Death 5, 2007 5:45 Ā M			
	Examin	70.	4a. Facility Name (If not institution, give street and number) Pickersgill	4b. City, Town, or Location of Death		c. County of Death			
	. Funeral Director		5. Social Security Number 100-07-4040 6. Sex 1 M 2 M F 92 Yrs.	TOWSON // If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year June 26,	Baltimore 9. Birthplace (State or Foreign Country) 1915 New York			
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits			
	he Man 8a-f sh olilled	Director		imore		1 ∑ Yes 2 □ No			
980	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23c or 28a-1 show event, the Mcdical Examinat must be notified at	al Dir	100. Street and Number 1411 Hollins Street	10f. Zip Code 21223		Citizen of What Country?			
		by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 No Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	n 72 ho "natur	leted	(Specify only highest grade completed) (Given life	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry			
	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 AC	countant		Insurance			
and	ld be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last) William Anthony Schoen		e <i>(First, Middle, Maide</i> ie Hersher	an Sumame)			
Maryland	2 should be and Mental is marked or raumatic ev	}-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	s 1 and f Health item 27 other t		20a Method of Disposition 20b. Place of Dis	1 Hollins Street, E		MD 21223 Location - City or Town, State			
Baltimore,	Page ment o tant: If jury or		4 Donation 5 Other (Specify)		1	Bethlehem, PA			
Ball	permit. Pages 1 and 2 should be Department of Health and Menis Important: If item 27 is marked any injury or other traumatic e once.		21. Signature of Foreral Service Licensee	22. Name and Address of Facility Ruc 1050 York Road, Tow	ck Towson wson, MD	Funeral Home, Inc. 21204			
8	Physician /Medical Examiner street and physician and street stree		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on entering the control of t						
			disease or condition resulting in death) Due to (or as a consequence of):	~ 14		Jean			
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
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8760,		dical E	Due to (or as a consequence of):						
9	ertificat ding phy se as th	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy						
.O. Box	at the death certific by the attending partected for use as	Physician/Me	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year			
ds, P	es tha gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? No 3 Probably 4 Unknown			
Record	or Attending Physician: The law fer death. lirector: After this certificate has b inector: After this certificate has b n by the funeral director, page 2 si	ompleted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
		O			performed?	death?			
f Vital		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpate	Othor	th (Check only one) ome 5 ☐ Residence	6 ☐Other (Specify)			
on of			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)		28d. Describe how in	jury occurred			
Division		ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)			
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	calC	29a. Certifier (Check only (C						
	To the within 2 Fo the complet	Medi	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)			
			Misky Kly -	025205	Se	Aubu 17, 2007			
	12		30. Name and address of person who completed cause of death (Item 23a) (Typ W, A. R.7., Game 67.01 M	Chule St. 5	etto mo	Aubu 17, 2007			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	nauli)					

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ruth Laurinda Mitchell /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) Examiner altimore nklin Square Center usedale (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Davs Hours Min. 1 M 2 XF W VA Jul 25, 1917 216-32-1505 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Essex 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 Barron Ave Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes XXX No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XXNo Specify: Specify. þ White 30X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Booth Weese H. C. Weese ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 912 Barron Ave, Essex, MD 21221 Jerry Jordan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Sep. 19,2007 Belington, W VA 4 ☐ Donation 5 ☐ Other (Specify) Fraternal Cemetery of Funeral Service L 22 Name and Address of Facility, P.A. 426 Crain Hwy S., Glen Burnie, ND Gregory Fink M01148 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, shock, heart failur Lis Immediate Cause (Final disease or condition resulting in death) 10 days **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as e esn IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 Unknown 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No after death. 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours at To the Funeral C 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month **Physician** Year Sept 3:06 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) HOSPITAL 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) \$4 Yrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 3 SOUTH CAROLINA Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Wedical Examiner must be notified at 1 XYes 2 No Director 10e. Sweet and Number filed within 72 hours after death with Completed by Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GRADE LINE WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be WARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIE MAE 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FORESTO9-4 Donation 5 Dother (Specify) OWINGS MILLS 21. Signature of Funeral Service Licenses JR. FUNERAL 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. Immediate Cause (Final Isease or condition resulting in death) **Physician** Due to (or a a consequence of) Adenocarcimons LyC /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 st ould be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy performed? Yes _2 \(\square\) No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Matthew 5. Baron D.O.

D.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital, MD

12

2007

AT 2438946 HZ

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar 8 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year SEPTEMBER 13, 2007 RICHARD E. PARTHREE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2904 CHESLEY AVENUE BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**√** M 2 □ F 216-30-6078 Director 12/19/1932 MARYLAND 74 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 TYYes 2 ☐ No MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2904 CHESLEY AVENUE 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo ģ Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION TRUCK DRIVER 10TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNAVAILABLE UNAVAILABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL B. PARTHREE/WIFE 2904 CHESLEY AVENUE BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 9/15/2007 CATONSVILLE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Mes 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disea of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) mon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Examin attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 115546 Sept. 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 5601 Lock Raven Blue, Brillimore, MD 21239 Padaett, MD 31. Date filed (Month, Day, SEP 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Physici /Medic		Mary C. Pilla	38					Septemb	er 13,	Year 2007	2:00 1	РМ
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Funeral Director		215-09-0075	1□ M 2\X		Yrs. Months		Hours Min.	8. Date of Birth Month, Day Jan 30	, 1915	9. Birthpla Counti Mar	y) yland yland	iign
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th the	irec	10e. Street and Number			10f. Zi	p Code		10	0g. Citizen of V	Vhat Count	y?	
ath wi	ral	108 West Semina	ry Ave.			21093			USA			
Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If litem 27 is marked other then "natural", or liteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at sone.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates	?] No	13. Was Dece If Yes, spe		spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - America k, White, e		
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and 2 and 2 and 27 in 27 in		Jeffrey Pillas	(son)					herville		1093		
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	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic po 5 □ Other (sp				23d. Date Mor	of delivery th D	ay Year	
ds, P urres that o signed b	<u>م</u>	Part II. Dther significant conditions of	contributing to death t	but not resulting in	the underlying o	ause giver	in Part I.	23e. Did toba			cause of death?	vn
Cord W requir s been s s should	lete	atriali	Sprille	ition				24a. Was an			y findings availab	
Division of Vital Records, for Attending Physicien: The law requires to effer death. Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	Completed							autopsy perform	D	nor to comp eath?	letion of cause of	
f Vit		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Other	700	h Check only one				
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Divis	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Place of In	jury - At home, fam tc. <i>(Specify)</i>	n, street, factory	r, office		28f. Location (Stre City or Town,	eet and Numbe State)	r or Rural F	oute Number,	
9 2 2 8 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	edical	29a. Certifier (Check only one) 1 □ Certifying Ph 2 □ Medicaf Exar	nysician: To the best niner: On the basis o and manner st	or examination and	death occurred for investigation	at the time , in my opir	, date and place, nion, death occur	and due to the cau red at the time, dat	use(s) and mar e and place, a	ner as state nd due to th	id. e cause(s)	
To t within To t com		29b. Signature and title of certifier	01.0	\		License ([7]	d. Date signed	(Month, Da	y, Year)	
		30. Name and address of person who	completed course	Jacob (fram SS:) =	_	100	5134	1 /	7/13/	01		
4		C. SOCIANO MD	6701 N.	charle.		Balt	imore	MDZ	1204			
State Registra	_	31. Date filed (Month, Day, Year)	32. Ré gistr	ar's Signature	boarde	9		·				

State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HENRY ALBERT PETZ JR. **SEPTEMBER** 11, 2007 6:30 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 216**-**16-5923 84 Dec. 8, 1922 Maryland Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1403 Purdue Court 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If-Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Specify: 3 Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Henry Albert Petz Sr. Ethel C. Petz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Patricia Lee Petz / Wife 1403 Purdue Ct., Bel Air, MD permit. Pages 1 a
Department of Her
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 9-14-07 Timonium, Maryland Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uriknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 1 🗌 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 ER/Outpatient 3 DOA Marur of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural Injury 5 Pending within 24 hours after deau..

To the Funeral Director; Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 669 REVOLUTION STREET JEAN T. LEE HAVRE DE GRACE, MD. 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

State Registrar

30. Name and addre

Ajay Reddy, 6320 Democracy Boulevard Bethesda, Maryland 20817 M.D. 3 Registrar's Signature 31. Date filed (Month, Day Year) SEP 1 8 2007

n who completed cause of death (Item 23a) (Type, Print)

D53691

September 13, 2007

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND TIPM#20c, perFH, 871, 9/18/07, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year ternandes SEPTEMBER 11,2007 07:00AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Center Towson Baltimore 8. Date of Birth (Month, Day) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F -95-334 Months Days Hours Yrs Director Usual Residence of Decedent with the Maryland 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director 1 Yes 2 No nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a (must b 21229 nden Hvenue death v Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian, ortant: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2□ No þ Specify: 3 Widowed 4 Divorced Specify: Blac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "n: any injury or other traumatic event the conce. (Give kind of work done during most of working -life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ve ld:na 17. Father's Name (First, Mide Be er's Name (First, Middle, Maiden ပ္ uintana a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Streetland Number or Rural Route Number, City or Town, State, Zip Code) Cousin 88*7*0 21045 Nanuel IND ame umbia Dirc 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition WAK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Ware and Address of Far Greene Funeral Services Ito, mo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NON-SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dun to (or es a nonsequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS TYPE II 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has 24a. Was an autopsy certificate Division or Vital 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) death, 1 ☐ Yes 2 ☐ No Director: the 6 Could not be determined n 24 hours after der ne Funeral Directo oletely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical сопрletely (Check only one) the 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Dav. Year) D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON POH LIM. M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 18 SEP Registrar

amend items 7 and Department 87 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 13 2007 **Physician** Juanita E. Quade-McCreer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ELEN BURNIE SALTIMORE IS HEHMYTON MEDILAL CENTER if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 29, 1923 Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Months 1 □ M 2 🕅 F West Virginia 84 Director 407-22-3042 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Glen Burnie Anne Arundel 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 392 Arcane Court 21061 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 Il Hygiene. than, Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant and Mental Hygi Is marked other and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and 2 should be fi lealth and Mental H Charles Cremeans Stella Thacker injury or other traumatic Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai once. Virginia Rippel-Daughter 5502 Cynthia Terrace Baltimore, Maryland 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 9 Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 8/17/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. By ter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck in heart fail in the only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** theumonic /Medical Due to (or as a consequence of): Examiner OBGREUZTIVE TULMONAR CHRONIL Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed MENTID and Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signaturan 29c. License number 29d. Date signed (Month, Day, Year) mi dress of person who complete cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

me and a

31. Date filed (Month, Day)

ospital

strar's Signature

07-07164 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lucretia Russell State of Maryland / Department of Health and Mental Hygiene 2007 29830 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 15, 2007 0128 hrs Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Baltimore County** I 83 South Bound South of Ruxton Road **Baltimore City** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8: Date of Birth (MM/DD/YYY) g. Birthplace (State or 5 Social Security Number 6 Sex **Funeral** .35 ·Hours Director Country) Man М 2 V Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 23a or 28a-f show notified at once. Manyland with the Maryland rector 10g. Citizen of What Countr 10e. Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? death ' Never Married Yes No ō Yes 2 No specify: Widowed Divorced If Yes, Give Year Specify. itera 27 is marked other than "natural", traumatic event, the Medical Examiner 6 15. Decedent's Education (Specify only highest-grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within 72 21215-0036 Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pullinas Be James lares Pages 1 and 2 should be nent of Health and Mental 19a: Informant's Name/Relation Type, Print (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kussell-husban ₹ Rambling 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, 2 Cremation 3 Cemeter Woodlaws Other Specify Donation 5 22. Name and Address of Pacility 21. Signature of Furleyal Service License Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed attending physician and or use as the burial - tran Physician/Medical 10e per fh g871 9-27-07 vt X AMENDED UNPENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months 4 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a Was an certificate has been autopsy death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 1 V Yes မ 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death

Cart

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Year

September 15, 2007

Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No Certification: Pedestrian struck by tractor-trailer Sep 15, 2007 0120 hrs 1 Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) South Bound 83 near Ruxton Road, Baltimore, MD (Specify) Major Road / Highway Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and tile of

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

Registrar

31. Date filed (Month, Day, Year) SEP 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29831 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Vear **Physician** 2:49 AM RANSON E. RUNKLES 09 2007 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A HOSPITAL BALTIMORE GOOD SAMARITAN 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F Days Hours MARYLAND 215-16-0855 86 Director 30/1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland 10h County r 28a-f sh notified 1 ☐ Yes 2 ☐ No Director BALTIMORE PARKVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be r 21234 8820 WALTHER BLVD. APT. 4302 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: WHITE 3 XWidowed 4 ☐ Divorced WWII other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE BALTIMORE SUN PAPER COMMERCIAL ARTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental ELIZABETH FOTHERGILL HANSON H. RUNKLES ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 THETFORD ROAD TOWSON, MARYLAND 21286 LANCE S. RUNKLES/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Important: If It any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 09/17/2007 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BRADYCARDIA /Medical Due to (or as a consequence of): Examiner FAILURE ESPIRATOR Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown MULTIPLE MYELOMA 1 Tes RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral I

completely filled 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Jo 4)

State Registrar 31. Date filed (Month, Day, Year)

SEP

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2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAMS QUAZI, GQOD SAMARITAN

M.D.

GOOD SAMARITAN HOSPITAL, 5601 LOCHRAVEN BLVD, BALTIMOREN

KES 000

07-07185 Ruben Renta

ben Renta		State 1- For State Registrar	e of Maryland /		artment of			Mental I		20 ag. No.	07	29	83
Physicia edical Exami	an/	Decedent's Name (First, Middle,La Ruben	est)			Re	nta		2. Date of Deat Month Septembe	h	1	e of Death 27 hrs	
		4a. Facility Name (if not institution, g						ocation of Dea		4c. County of D	eath		
Funeral	_	Hansen Road and Silverl 5. Social Security Number 6.3		e (In yrs. I	ast birthday)	Edgev If Unde		If Under 24H	Irs. 8. Date of Bir	Harford th(MM/DD/YYYY) 9.	Birthplace	(State or	
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212 212 201d be 201d be 301d b	ro Be	Jaime Renta 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street		Santia or Rural Route Num	ago nber, City or Town, S	State, Zip Cr	ode)	
MD nd 2 sho alth and m 27 is		Jaime Renta-Br	cother	1	7891	W F	lage	er St	Apt 227	, Miami	, FL	331	44
Baltimore, MD 21215-0036 germit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Importment of Hand Mental Hygiene. Importment of time 27 is marked other than "natural", or items 23a or 28a-f she injury or other trauntatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 X Burial 2 Cremation 3		ite	Place of Dispos crematory or ot	her place)		, l.	Date	20c. Location - Cit			n
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5876 ertificat ling phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon		2 F6	etal death	3	Ectopic preg	gnancy	23d. Date of del Month	ivery Day	Yea	ar
Box 6876(he death certificate the attending physhed for use as the b	Physician/M	1 Yes 2 No 9 Unknow	4 Pregnant at yn g Unknown	time of de	eath 5 O	ther (Spec	ify)						0
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Division of Vital Records, and or Attending Physician: The law requirers after death. In Director, After this certificate has been sited in by the funeral director, page 2 should be	Certification:	2 Accident Investig: 3 Suicide 6 Could in	ot be 28e. Place of In			et, factory,	office bu	ilding, etc.		Street and Number of State) & Silverbell Drive			er, City
a of the state of						rred at the	time, date	e and place, a				od, MD	
To the within To the To the	Medical	one) 2 Medical Examin				tion, in my	opinion,	death occurre				e(s)	
	Σ	29b. Signature and title of certifier	011.00			29c	License. O.C.M			29d. Date signed September 16		ıy, Year)	
to		30. Name and address of person wh	o completed cause of d	eath (Iten	n 23a)								
Q			Assistant Medical			enn Str	eet, Ba	ltimore, MI	D 21201				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature.													

07-07137 Leslie Ross Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 29833 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 14, 2007 0138 hrs Leslie E. Ross Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death N/A Baltimore Good Samaritan Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** oreign**Massachusetts** Country) Min. Months Davs Hours 008-18-5954 Director 07-15-1929 78 2 1 X M Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a State 1 X Yes 2 No Baltimore : 23a or 28a-f show : notified at once. N/A 28a-f show Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21214 USA 5213 Catalpha Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? Never Married 2 X Married 1 X Yes If Yes, Give Year Specify: Yes 2 X No specify: White 3 Widowed Divorced the Medical Examiner 'natural", ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fields and Grounds Supervisor Johns Hopkins than nt: If item 27 is marked other other traumatic event, the Me 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Fowler Roy Ross Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5213 Catalpha Road Baltimore Maryland 21214 Jai Nam Ross/Wife 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place)
Hilltop Service Corp. Burial 2 Cremation 3 Removal from State 9/17/07 Towson Maryland tant: Other Specify Donation 5 ²² Name and Address of Facility Feograph of Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee felter 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death 'Medical Right leg hematoma complicating hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED 27,28a-f, perME.g872. 10/2/07 TT **Y** UNPENDED the attending physician ed for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o \$ Yes 2 No 3 Probably 4 ✔ Unknown σ. Completed Records, 24b. Were autopsy findings available 24a, Was an t, page 2 sh prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No i√ Yes 2 certificate 26. Place of Death (Check only one) 25. Was case referred to medical Physician: Division of Vital Be Other; Hospital: 1 Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 V Yes No 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: Afte Yes 2 XNo Natural Pending subject injured leg Director: July 26, 2007 unk 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of injury - At home, farm, street, factory, office building, etc. or Town, State)
5213 Catal ha Rd Baltine II 3 Could not be Suicide determined (Specify) Homicide other-residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 14, 2007 O.C.M.E. 30. Name and address of person who complete cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year

Registrar

32. Fegistrar's Signatur

07-07126 Aaron Rivera Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 29834

IOII KIVEIA		1-For State Critificate of Death		200	1 2300
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death		3. Time of Death
Filysicii cal Exami	2111/	Aaron Kivera	Month Day September 13,	Year 2007	1642 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		c. County of Death	
		325 S. Woodyear Avenue Baltimore		NA	
Funeral	\Box	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr		/DD/YYYY) 9. Birt	nplace (State or
Director		218-100-8085 14M 2 F 53 Yrs. Months Days Hours Min	9-19-1	953 00	Many and
		Usual Residence of Decedent			
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
and show	5	hd N/A Baltimore	E		1 Yes 2 No
Maryl 28a-1	ect	10e. Street and Number 10f. Zip Code	10g. Cit	tizen of What Cour	try?
3a or	اق	325 S. Woodyear Ave 21223	= -	4.5.7	
death with the Maryland or items 23a or 28a-f shunus be notified at once	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ Never Married 2 Married 2 Married Proces? 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ If Yes, specify Cuban, Mexican, Puert		14. Race - Ameri White, etc.	can Indian, Black,
r deat	Funeral Director	1 Yes 2 No		Specify: Ba	-6
s afte	ğ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Kind of Business/I	
2 hou "nat	ted	Elementary/Secondary (0-12) College (1-4 or 5+)			
0036 within 72 hours giene ner than "natur Medical Exam	nple	t2 2 laborer		4: crof	ming
5-0C ed wit lygier other hc M	Completed		e (First, Middle, Maide		[
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be	trancisco Kivera Myr	tle Boy	d	
21 hould of Me is ma	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	Rural Route Number,	RIL	1 1
nore, MD 21215-0036 gass I and 2 should be did within 72 hours after death with the Maryland nt of Health and Mental Higgene. It item 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.		20a, Method of Disposition (Name of cemetery)	Date 20c	Location - City or	Town, State
of He		1 Burial 2 Cremation 3 Removal from State crematory or other place		D / 1	1 Mil, State
도요일들는		4 Donation 5 Totaler Specify.	18-2007	120/10	, /0-0.
Baltimore, permit. Pages La Department of He Important: If ite injury or other t		21. Signeture of Funeral Service Licensee 22. Name and Address of Facility and	Balto.	Service ld. 212	17
		23a. Part I. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac	. 2011		Approximate Interval
Physician 'Medical		failure. List only one cause on each line.			Between Onset and Death
_xaminer		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular disease Due to (or as a consequence of):		_	
		Sequentially list conditions, b			,
	ner	if any, leading to immediate cause. Enter Underlying Cause			
	aminer	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
outed nd ransit	EX	d			
O, e be exec ysician a	Medical	X UNPENDED #23a,PII,27,perME,g872, 10/3/07 TT			
760, icate be exi physician the burial		IF FEMALE: 23c. If yes, outcome of pregnancy	ı	3d. Date of deliver	
Sox 687 leath certific e attending I for use as ti	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	Month	Day Year
Box 687 e death certific the attending 1 ed for use as t	ysic	1 Yes 2 No 9 Unknown g Unknown			
D. B. It the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
, P.O ires that t signed b	d by	Cocaine use	1 Yes 2	No 3 Pro	oably 4 🗸 Unknown
ords v requir s been should	Completed		24a. Was an autopsy		utopsy findings available completion of cause of
e law e has ge 2 sl	l dm		performed	? death?	
tal Recional Recional Continuation The certificate rector, page	ပြိ	25. Was case referred to medical 26.Place of Death (Chec		10	2 110
Division of Vital Records, the low requints after death. an Director. After this certificate has been if led in by the funeral director, page 2 should the in by the funeral director, page 2 should the death.	Be	evaminer?		dence 6 🗸 Othe	r: Scene
ing Phy After th	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how i	njury occurred	
On tendin sath. or: A	흘	Natural 5 Pending 1 Yes 2 No			
ViSi or Att filer de Direct	liga I	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stree or Town, State)		ural Route Number, City
pital ours al	Certification:	4 Homicide determined (Specify)	or rown, state)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a me) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre	nd due to the cause(s)	and manner as sta	led.
To the comp	Medical	and manner stated.		d. Date signed (Mo	
	≥	29b. Signature and title of certifier 29c. License number O.C.M.E.		eptember 14, 2	
		Color Africa -			
		 Name and address of person who completed cause of death (item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 	201		
	State				
Regi		Marke !			

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 29835 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Vernon Edward Rineheart 11, 11:50P M September 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Holly Hill Manor Towson Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9 - 27 - 11 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ¥EXM 2□ F Months 214-20-4576 94 -1912 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other than "natural", or Items 23a or 28a-f shent, the Medical Examiner must be notified Maryland N/A Baltimore XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 A. Cross Keys Road 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ Specify: **3** Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur Washington Rineheart Hattie Virginia Meldron P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Rineheart Son 115 A. Cross Keys Road Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of I-Important: If ite any Injury or ott 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Pk 9/17/2007 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 First 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of ficause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: MA 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 □ Pregnant at time of death 9 □ Unknown Month Year Day 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ို 1 Inpatient this filled in by the funeral 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place o injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7402 YorkRead took 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

Certificate of Death

	For State Registrar		Department of Health and Certificate of Death	i Mentai Hygien Reg. N		29836
Physician	1. Decedent's Name (First, Middle, L	ast)	ROBINSON	2. Date of Death Month D SEPTEMLER	av Vear	Time of Death
/Medical Examiner	4a. Facility Name (If not institution, g		4b. City, Town, or Location of De BALTIMORE		c. County of Death	•
neral ector	5. Social Security Number 6.	Sex 1 M 2 1 7. Age (In yrs. last birt	(hday) If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birthplace Country)	(State or Foreign
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	n or Location	nounce sept.		nside City Limits
Examiner must be notified at by Funeral Director	MARVLAND 10e. Street and Number	NIA	10f. Zip Code		itizen of What Country?	Yes 2□No
al D	2863 WO	ODBROOK AVEI	VUE 212,	17	USA	
	11. Marital Status 1 ☐ Never Married 25€ Married	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American In Black, White, etc. Specify: /2	dian,
eted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest)	Year or Dates: Education 16a.	Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired)	vorkina I	Kind of Business/Industr	CK_
Completed	Elementary/Secondary (0-12)	4 VRS	life. DO NOT use retired) SUPERVISO		UISH FAMILY 4CH	LOREN SERVICE
To Be C	17. Father's Name (First, Middle, La	st)	ACKSOAL MAA	lame (First, Middle, Maide 2THA		
-	19a. Informant's Name/Relationship	(Type. Print) 19b	. Mailing Address (Street and Number or	Rural Route Number, City	or Town, State, Zip Coo	le)
02	DE BORAH GHE 20a. Method of Disposition	comoto	Disposition (Name of cy, crematory or other place)	Date 20c.	ALTIMORE M Location - City or Town,	10, 21216 State
	1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify) WOOD	LAWN CEMETRY D9	-21-07 W	ODLAWN,	MD
once,	21. Signature of Funeral Service Lie	HN. William	22. Name and Address of Facility	, BROWN-	JR, FUNERA BALTO, ML	L 140ME 0 21217
	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	omplications that caused the death. Do not one cause on each line.			Apr Inte On	proximate erval Between set and Death
ian cal ner	disease or condition resulting in death)	a. Due to (or as a consequence		1 .	5	BAYS
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	of):			
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence	of):			
edical		d				
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	9	23d. Date of delivery Month Day	Year
		s contributing to death but not resulting in		23e. Did tobacc	o use contribute to the ca	ause of death?
sted b	INSULIN DEPE	NDENT DIABET	TES MELLITUS			4 Unknown
Completed by				24a. Was an autopsy performed 1 Yes 2 ☑		findings available tion of cause of
Be	25. Was case referred to medical examiner?	Hospital:	l 045	Death (Check only one)		
2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	g Home 5 ☐ Residence 28d. Describe how in		
ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Injury Work? M 1 ☐ Yes 2 ☐ No			
ertific	3 Suicide 6 Could no 4 Homicide determin		arm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Ro ate)	ute Number,
Medical Certification:	29a. Certifying (Check only 2 Medical E.	Physician: To the best of my knowledge kaminer: On the basis of examination ar and manner stated.				
Mec	29b. Signature and title of pertifier		29c. License number		Date signed (Month, Day	,
	1 G. G. G	Ja M D	RES 000	Sel	TEMBER 14	7007
		ho completed cause of death (Item 23a)	(Type, Print) SINAI HOSPI	TAL OF B	ALTIMORE	
State		32. Registrar's Signature				

State Registrar

SEP 1 8 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 15, 2007 **Physician** Helen В. Reese 3:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 028-20-7725 Director 85 September 12,1922 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits notifled at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6 must be or items 23a 10625 Muirfield Drive 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 ☐ Widowed 4 🕅 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Karl W. Battis Anne Erler မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan R. Reese / Son 8510 Victory Lane, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 ☐ Burial 2 II Cremation 3 ☐ Removal from State 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bei
7557 Wisconsin Avenue, Bethesda, Mai
23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Immediate Cause (Final disease or condition resulting in death)

a. September 1. September 2. September 3. S Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical ası IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 5 Other (specify) signed by the a No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be 22 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA patient 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Watural (Month, Day Year) 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, Division or Vital Records,

s after death. within 24 hours at To the Funeral D completely filled in Hospital the

20

Registrar

(Check only one)

29b. Signature and title of certifier

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

1119 Roberto Clastiscan,

31. Date filed (Month, Day, 32. Registrar's Signature 5 1 8 2007

DHMH 17 Rev 1/2001

Registrar

8 2007

			1 - For State 6	of Maryland /		rtment of H			giene Reg. No.	007	29839	
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	MAN				2. Date of De.	Day	Year 12, 6	3. Time of Death	
	Examir Funeral		4a, Facility Name (If not institution, give street and not be sold to be sold	7. Age (In yrs. last b	irthday)	4b. City, Town, or If Under 1 Year Months Days	16 Under 24 H	Hrs. 8. Date of Birt	h v. Year)	ounty of Death		
	Director		577-56-6634 Usuaf Residence of Decedent 10a. State 10b. County	90	Yrs.			Sept. 1	6,191	6 It	aly	
	death with the Maryland me 23a or 28a-f show rman be rolling at	ector	Maryland Carroll 10e. Street and Number		odbi	ne			10- 000		1 ☐ Yes 2√ No	
	3a or	i Dir	15300 Bushy Park Roa	ıd		10f. Zip Code 2179	7			n of What Co J.S.A.	untry !	
336	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or itame 23s or 28s-f show any folury or other traumatic event, the Medical Examinat must be notified at ance.	by Funeral Director	Amed F	2 MNo ive	1	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		. Race - Ame Black, White pecify: W		
21215-0036	within 72 houlene. Then "nature he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College	1-4or 5+)	(Give k life. D	ent's Usual Occupa ind of work done of O NOT use retired, sewife	ation luring most of t	working		of Business/		
Maryland 2	ould be filed withi Mental Hygiene. arked other ther atic event, Inc.M	To Be Co	17. Father's Name (First, Middle, Last) Victorio DeBernardo		nous	SCWIIC		Name (First, Middle, sa DeBerna	Maiden Su	en Sumame)		
lary	2 should and Men is marke	[·	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Street a	nd Number or	Rural Route Numbe	or, City or T	own, State, Z	Tip Code)	
altimore, N	Pages 1 and 2 nent of Health int: if item 27 iny or other tra		William Rangan (Son) 20a. Method of Disposition 1 Removal from 1 Removal from	State 20b. Place of cemeter	of Dispos ery, crem	Bayshore ition (Name of atory or other place	9)	Date	20c. Loca	tion - City or		
Baltir	permit. Page Department of Importent: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	MUIOSO	₩1	leaven Ce Name and Addres tzke Fun 55 Twin	s of Facility eral Ho	mes, Inc.		a, MD	ing, MD 21045	
8760, <	Physician and // Medical Examiner and the prutal-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	strok	e of):		g, such as card		rest,		Approximate Interval Between Onset and Death	
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		Physician/Medical	in the past 12 months?	itcome of pregnancy birth 2 Fetal death nant at time of death own		Ectopic pregnancy Other (specify)			230	d. Date of deli Month	very Day Year	
rds, P.	w requires that been signed by should be deta	by	Part II. Dther significant conditions contributing to a	eath but not resulting	in the un	derlying cause give	n in Part I.	23e. Did to			the cause of death?	
Division of Vital Records,	iician: The law re certificate has ber rector, page 2 sho	Completed	A COMPANY OF THE PROPERTY OF T							24b. Were au prior to d death? 1 \(\text{Yes}	topsy findings available completion of cause of	
Ę	ysicial s certil directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) Yes \(2 \text{No} \) No Hospital: 1 \(\text{I} \)	Inpatient 2 ER/O	utpatient	3□ DOA Othe		Death Check only of Home 5 Resid		Other (Sne	764	
sion of	To the Hospitel or Attending Physician: The within 24 burs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: T	27. Manner of Death 1 Natural 5 Pending (Mod 2 Accident investigation	of Injury 28b.	Time of Injury	28c. Injury Work		28d. Describe			ary)	
<u>X</u>	itel or Attendurs after deatlus after deatlus linector:		4 Homicide build	e of Injury - At home, fing, etc. (Specify)				City or Tou	n, State)		ral Route Number,	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	2	pasis of examination at iner stated.	nd/or inve	estigation, in my op	inion, death or	ccurred at the time,	date and pla	ace, and due	to the cause(s)	
)	F X F 8		1 Kan 1196	7		194	1617	7.	500	+ 17	2007	
1			30. Name and address diperson who completed cau	se of death (ftem 23a) FOT HICL	(Type, P	y Ridre	2 Rd	Columbi	E,1	nd -	2, 2007 21045	
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 1 8 2007	legistrar's Signature	A STATE OF THE PARTY OF THE PAR	rues?						

07-06976 Robin Simmons

KOBIN SIMMON	5	State of Maryland / Department 1- For State Registrar Certificate	of Death	g. No. 2007 2984
Physic Medical Exam		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	h 3. Time of Death
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
<i>_</i>		Harford Memorial Hospital 5 Social Security Number 6 Sex 7. Age (In yrs. last birthda)	Aberdeen	Harford
Funeral Director		215-48-1528 1 MM 2 F 51	y) If Under 1 Year If Under 24Hrs. 8. Date of Birt Months Days Hours Min. May 24	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
aux		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation .	10d. Inside City Limits
	5	m) Harford Abero	leen	1 Yes 2 4No
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number	10f. Zip Code	g. Citizen of What Country?
vith the	al D		2/00/ . Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
death v r items	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
s after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:	Specify: White
5-0036 led within 72 hours after death with the Maryland 'Hygene.' other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind of work doneing most of working life. DO NOT use retired)	16b. Kind of Business/Industry
1036 Athin 7 ene. or than	Completed	12 (0	NSTRUCTION WORKER	Construction
	Be Co		18.Mother's Name (First, Middle, N)
2121 2121 Duld be fil I Mental F I marked ic event,	To B		ailing Address (Street and Numb or Rural Route Num	ber, City or Town, State, Zip Code)
imore, MD 2 Pages 1 and 2 shou nent of Health and Nant: If item 27 is no or other traumatic		Kelly May - Daughter 14	O Jethro St., North	11.100
Baltimore, ME permit Pages I and 2 s Department of Health as Important: If item 27 injury or other traum:			sposition (Name of cemetery, Date or other place)	20c. Location - City or Town, State
Itimo iti Pagi irrment ortant:	-	4 Donation 5 Other Specify: Bay VI 21. Signature of Funeral Service Licensee	22. Name and Address of Faility Post of 181	Balhmore, MD
Balt permit Departe Import Injury	,	AXLO LA	Home, P.A. 2134 4)	1 Ashton Funeral 110W Spring Rd. 21222
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Complications of chrorous pue to (or as a consequence of):	nic ethanolism	Death
		Sequentially list conditions, b.		
	niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Dispace Enter Underlying Cause)	er i stalle	
igi eq	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
execut ian and	Medical	XUNPENDED AMENDED AME COZI O	/10/07 mm	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	/Med	XUNPENDED AMENDED, 7, perME, C871, 9/ #2a, 27, perME, C871, 9/ 23b. Was decedent pregnant in the		23d. Date of delivery
Box 687 death certific he attending p	ician	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
ion of Vital Records, P.O. Box tending Physician: The law requires that the death feath. tor: After this certificate has been signed by the atte the thoreal director, page 2 should be deached for u	Physician/I	1 Yes 2 No 9 Unknown g Unknown		
ires that the signed by the detached	by	Part II. Other significant conditions contributing to death but not resulting in t		bacco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
ords, w require s been si	Completed		24a. Was a	
Reco The law icate has	dmo		autops perfor	med? death?
tal Recition: The certificate	Be C	25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 of EP/Output	26.Place of Death (Check only one)	
Division of Vital Records, tal or Attending Physician: The law requir as after death. Al Director: After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should	유	1 ✓ Yes 2 No rospital 1 Inpatient 2 ✓ ER/Outpat 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time		Residence 6 Other:
ion (tending eath. tor: Af	ation	Natural 5 Pending	1 Yes 2 No	, , , , , , , , , , , , , , , , , , , ,
ivisi or Atr after d Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc. 28f. Location (S or Town, St	treet and Number or Rural Route Number, City
ospital hours uneral		4 Homicide determined (Specify) 29a Certifier Continue Devicing Table bot of pulses dead as dead on the continue determined of the continue dead of the continue determined of the continue dead of the continue determined of the continue		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or invesand manner stated.		
F 2 E 8	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		unal >	O.C.M.E.	September 9, 2007
		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner	n Street, Baltimore, MD 21201	
	tate	31. Date filed (Month, Day, Year) 32. R Sistrar's Signature	barti	
Regis	trar	SEP 1 8 2007 Silver St. A		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day DEPTEMBER 1 **Physician** SCOTT 200 /Medical ANNIE 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Battimere Northwest handallsta HOSPI tal Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Unde 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 □ M 2 X F Months Hours Director 07.09.1932 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan arthment of Health and Mental Hygiene.
ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Baltimore Windsor Nill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3416 Maryvale hoad Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 □ Divorced Blach Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ousewige 1-tome 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be he Wontgomery ဂ္ brdan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shanel Mainview court Thondallstown mp 21133 Taylor / Daught 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or 22. Name and Address of Facility Vaugha C. Green Juneau Sernes 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - iberty Mid Mandallstain mo 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NECROTIZING FASCITIS /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be execute and burial-trar Due to (or as a consequence of): the attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No certificate has autopsy performed 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: To the Hospital or Attending 1 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPlemberl m.C D41410 20% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER MEHTA

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

CENTE

HUSPITA2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 1,10c.e.f.,18,20a,b.c.,22 per Dr/FH, 9871,09/18/07dhb,19b State of Maryland Department of Health and Mental Hygiene 1- State Registrar Amend Items 25,29d,30 per dr. 9/18/07dhb Reg. No 2007 29842 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August 20, 2007 **Physician** Judith W. Saga1 Judy Sagal 7:50 PM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 8, 1943 9. Birthplace (State or Foreign Funeral Days 1 M 2 □ F Virginia Director 223-62-4809 64 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notifled at 1 ☐ Yes 2√ No Directo Silver Spring Rockville MD Montgomery 10e. Street and Number 6121 Montrose Rd 10f. Zip Code 10g. Citizen of What Country? 20852 15026 Westhome Court 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Mr Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. automation clerk federal government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Whitt Jane Chapman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15026 Lawrence Sagal/spouse Court Silver Springs, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4□Donation 5¥10ther (Specify) in state Chambers Crematory 8/28/2007 Riverdale, MD 22. Name and Address of Facilit Chambers Funeral. Home Street 5801 in Cleveland Aven, Rividale, MD 20737 21. Signature of Euneral Service Licensee Rona d S Wayte Director 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart fail ire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic cardiovascular disease 4 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hard 11 immediates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending phase as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by urosepsis, spina bifida, hypertension 1 🔲 Yes 2 **N**o 3 Probably 4 □Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) any August 28, 2007 50113 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date file

James W. Robey, M.D.,

7:50 PM

9/3407

Sagal, Judith

32. Registrar's Senature

8218 Wisconsin Avenue, Suite 407, Bethesda, MD

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 oug 195 Teuran /Medical 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death Examiner 4c. County of Deatl Medical No enter 6 5. Social Security Number If Unde If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (S A Gountry) A a b a 8. Date of Birth (Month, Day, Year) **Funeral** 258-07-3767 Months Days Hours Min 1 M 2 F Director -22-1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits death with the Marylan at 1 UYes 2 □ No must be notified **Funeral Director** Baltimore しょ 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant; If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be a U.S.A. 21217 193 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 þ Specify Specify: Black 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be ပ Honzo Teasa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Vto. Wynona 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Z Borial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 9-25-2007 21. Signature of Funeral Service Licensee Funnal S. Culla 110. 23a. Part1. Enter the disease, or complications that call sed the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical s a conseque ce of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? 9 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performe certificate or Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes ဥ Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Funeral Director: After completely filled in by the funer Certification: Division 1 Natural
Accident 5 Pending investigation Injury 1 TYes 2 TNo 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State

Lepas

(Month, Day,

DENR

- ma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 8 2007

Registra

Rene	Michelle	Shipe
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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certific	ate of	Death					Reg. N		00	1 4	704
Physicia	ın/	Decedent's Name (First, Midd	le,Last)							2.	Date of De				3. Time of De	
al Examin		Rene M. Shi									Septemi	per 1	1, 2007 ^{rea}		1616 hrs	6
		4a. Facility Name (if not institution		umber)			. City, Tow		ocation o	f Death			4c. County of	of Death		
		Rt. 140 East of Big Pi	pe Creek				Taneyto	own				Carroll				
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last bir	thday)	If Under		If Unde		8. Date of I	Birth (M	M/DD/YYYY		place (State	or Foreign
Director		213-02-3849	1 M 2XXF		36	Yrs.	Months	Days	·Hours	Min.	Aug.	1,	1971	Mary	yland	
		Usual Residence of Decedent		1									,			
any		10a. State 10b. County		10c.	City, Town	or Locatio	n							. 1	10d. Inside C	ty Limits
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or 29	Director	1550 Baust	Church Do	29				21.	791					TIC N		
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er death	교	3 Widowed 4 XDiv	1 Yes.	2 <u>XX</u> N	10		res 2 X	Na			- ;		04	Whit	to :	
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Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		21. Signature of Funeral Service		1)		22. Na	me and Ad	ldress o	of Facility	Dona	ldsor	ı Fu	neral	Home	e, P.A	
00 8 2 1 1		Januce	191/200	M01	103	31:	3 Tal	bott	t Ave	enue,	Laur	el,	, MD	20707	7	
Physician		23a. Pa (I. Enter the disease, or failure List only one cause	complications that	caused the de	eath. Do n	ot enter the	mode of o	lying, sı	uch as ca	ardiac or re	espiratory a	arrest, s		art	Approximate Between O	
/Medical £xaminer		Immediate Cause (Final disease	5.6 M	iuries							145				Dea	
Examiner	- 1	or condition resulting in death)	Due to (or as	a consequen	ce of):			_								
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	틸	(Disease or injury that initiated	Due to (or as	a consequen	ce of):				-			_				
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Sox 68 leath certi e attendin for use as	ici Si	past 12 months?		nant at time o	£ -1		er (Specify									
Box 68 te death certi the attendin ted for use a	JŞ.	1 Yes 2 No 9 V Un	known g Unkr	nown												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		Part II. Other significant condit	tions contributing	to death but r	not resultin	ng in the un	derlying ca	iuse giv	en in Pa	rt I.	23e. Dio	tobac	co use contr	bute to th	e cause of d	eath?
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Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide	rmined (Specify) Major R	load / H	ighway	_			Rt	. 140 Eas	t of Bi	íg Pipe Cre	ek, Tane	eytown, MD	iĭ
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Fo th ompl	Medical	one) 2 Medical Exa	miner: On the basis / and manner		on and/or	investigatio	n, in my op	oinion, d	death occ	curred at the	he time, da	te and	place, and d	ue to the	cause(s)	
- 3 - 0	žΓ	29b. Signature and title of certific	1				29c. L	icense	number			29	ld. Date sign	ed (Monti	h, Day, Year)	
/		1/6/	13/00	1, 1				D.C.M	.E.			s	eptember	12, 20	07	
1	1	30. Name and address of person	who completed call	ISS Of death (Item 23a)								-			
1			ssistant Medic			1 Penn s	Street, E	Baltim	ore, MI	D 21201	1					
Sta	ate	31. Date filed (Month, Day, Year)	32. F	gistrar's Sig		4									_	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29845 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day September 13, 2007 **Physician JENNIFER** LEE SUPSIC 4:15 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 8. Date of Birth (Month, Day, Year) Nov 29, 1 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1955 Wash., D.C. **Funeral** Months Days Hours 1 M 217-70-8885 51 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 □Yes 2 □No Director Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6926 Mayfair Road 20707 Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XX Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 📉 Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Admn. Secretary St.Mary's School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard B. Owen Josephine L. Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Supsic spouse 6926 Mayfair Road Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) W. Arundel Crematory 9/15/2007 Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. a ∠ M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Ent. the disease shock, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer 16 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the applies Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Ynknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 s 24a. Was an has autopsy death? 1 ☐ Yes performe certificate 2[**X**]**X**(0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XX ther (Specify) Hospice 1 ☐ Yes XIX No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred the Hospital or Attending XXNatural 5 Pending investigation Injury To the Hospina.
within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D 08754 September 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bensinger 7/25 Greenway Center Drive, Suite 205 Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) 32. Restrar's Signature

State Registrar

SEP18

2007

		partment of Health and Mental Hertificate of Death	lygiene Reg. No. 2007 29846		
Physician	1. Decedent's Name (First, Middle, Last) Edith R. Stedding	2. Date of Month	Death 3. Time of Death		
/Medical Examiner	Edith R. Stedding 4a. Facility Name (If not institution, give street and number) 2200 Pleasant Villa Ave.	Sept. 4b. City, Town, or Location of Death Catonsville	13 2007 3:00 p M 4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 237-20-9530 G. Sex 1 M 2 F 7. Age (In yrs. last birthda 7 Yrs. Usual Residence of Decedent	Months Dave Hours Min (Month	Birth 9. Birthplace (State or Foreign Country)		
vith the Maryland or 28a-f show be notified at Director	10a. State 10b. County 10c. City, Town or MD Baltimore Catonsv:		10d. Inside City Limits 1		
h with the 23a or 24 st be no	10e. Street and Number 2200 Pleasant Villa Ave.	10f. Zip Code 21228	10g. Citizen of What Country? USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Poparment of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural"; or my Injury or other traumatic event, the Medical Exami nose. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) he	cedent's Usual Occupation ive kind of work done during most of working by DO NOT use retired) comemaker	16b. Kind of Business/Industry own home		
yland 'S lould be filed Mental Hyg narked othe natic event,	17. Father's Name (First, Middle, Last) Dalton W. Bailey	18. Mother's Name (First, Midde Thelma Rea Dix	Kon		
Mar and 2 sh ealth and 1.27 is m		ulling Address (Street and Number or Rural Route Nur. Kensington Ln., Bloomfie			
MOCE Pages 1 gent of He nit: If Item ry or othe	20a. Method of Disposition 1	position (Name of rematory or other place) rematory 9/15/07	20c. Location - City or Town, State Catonsville, Md.		
Balti permit. Departm Importa any Inju once.	21. Signature of Linerar Service Licensee	22. Name and Address of Facility Sterling Funeral Home of Catonsvi 1630 Edmondson Avenue; C	Ashton Schwab Witzke		
ate be executed by sician and the burial-transit dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not easily shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):	enter the mode of dying, such as cardiac or respiratory of Charic closter outness	Onnet and Dooth		
Box 6 death certific death certific attending p d for use as ician/Mec		B⊟Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year		
w requires that been signed by should be detailed by Philipped by Phil	Part II. Other significant conditions contributing to death but not resulting in the		d tobacco use contribute to the cause of death?		
	corney Arty disrase	24a. Wa au pe 1 Yes	topsy prior to completion of cause of death?		
Physician: Thysician: To Be Co	25. Was case referred to medical examiner? 1 Yes	26. Place of Death (Check only ent 3 DOA Other: 4 Nursing Home 5 He	v one) ^ Sidence 6 □Other (Specify)		
Division or Vita tral or Attending Physician: rs after death. ral Director: After this certificated in by the funeral director, I Certification: To Be C	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	of	e how injury occurred		
- Isa Isa O	4 Homicide determined building, etc. (Specify)	City or T	(Street and Number or Rural Route Number, own, State)		
o the Hosp Ithin 24 hor o the Fune ompletely fi	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the tim	e cause(s) and manner as stated. e, date and place, and due to the cause(s)		
To 1 To 1	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
5	30. Name and address of person who completed cause of death (Item 23a) (Type	Print) NY4243	mp 21228		
State Registrar	31. Date filed (Month, Day, Year) 32 egistrar's Signature SEP 1 8 2007	rail I	-		

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			For State Ragistrar	State of	Marylaı		artment of F rtificate of I		nd Menta		ne 2007	29847
	Physic	ian	1. Decedent's Name (First, Min	ddle, Last)				,		te of Death	Day Yea	3. Time of Death
4	/Medi		William	Schmidt						x - 1	13 7007	
4	Exami	ner	4a. Facility Name (If not institu				4b. City, Town, or	4	Death		4c. County of De	
			Genesis Pen. 5. Social Security Number		-	. last birthday)	Park u	If Under 2	4 Hrs 0 Da	to of Dist		heral
	Funeral Director		217-16-4895	1 X M 2 ☐ F	84	Yrs.	Months Days	Hours	Min. Juli	te of Birth onth, Day, Ye Y	1923 ^{9. 8}	irthplace (State or Foreign Country) Maryland
	p ,		Usual Residence of Decedent									
	arylar show	5	10a. State 10b. Cour	*		ity, Town or Lo	cation					10d. Inside City Limits
	the M	ecto	MD Balt	imore	Par	kville	T					1 ☐ Yes 2V No
	ath with 123a or 3	rai Dir	8607 Richmond	Avenue			10f. Zip Code 21234			US	Citizen of What (Country?
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heatth and Mental Hygiene I Heatth and Mental Hygiene I Heatth and Sae or 28e-f show Itam 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Modical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Moivord	1/1/ 01	es? □No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origi n, Mexican, Specify:	in? (Specify Ye Puerto Rican,	etc.)	14. Race - Am Black, Wh Specify:	
5-0036	2 hou	ted	15. Deced	ent's Education		16a. Deced	dent's Usual Occupa	ation		16b	. Kind of Busines	
218	within 7 lene. than "n the Mcd	pie	(Specify only high Elementary/Secondary (0-12	hest grade completed) College (1-4	or 5+)	(Give	kind of work done of DO NOT use retired	luring most o)	of working			aoossy
21	filed wi Hygien Ithar th	Completed	10			Mailro	oom Clerk			De	partment	of Educatio
Maryland	ould be fited with Mental Hygiene arked other thei	Be	17. Father's Name (First, Midd						s Name (First,		den Sumame)	
ž	should nd Men marke	2	John C. Schmi 19a. Informant's Name/Relatio			405 14.25	4.11		na G. G			
Ma	and 2 sho satth and n 27 Is m		Adele Walter	/ sister	•		g Address <i>(Street a</i> Richmond					
re,	permit. Pages 1 and 2 Department of Health Important: If Itam 27 I any injury or other tra once		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date		Location - City o	
Baltimore,	Page nent o nt: If ry or		1 Burial 2 Crematio	n 3 □Removal from St (Specify)	uto		natory or other place ley Mem Gar		17/07		monium,	
atti	permit. Departming importa any inju		21. Signature of Fun Val Service	7 4	Dan		. Name and Addres		717707		1050 Yor	
8	89 2 2 3		1/etal	Ja Clay		Ru	ick Towso	n Fune	eral Ho			MD 21204
П			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cau ist only one pause on eac	sed the deat h line.	h. Do not ente	er the mode of dying	, such as ca	ardiac or respir	atory arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or	as a conseq	juence of):						
		<u>ا</u>	Sequentially list conditions,	b. Due to (or	as a conseq	mence of):						years
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	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	CDue to (or	as a conseq	uence of):						
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	artifica ing ph a as th	Med	IF FEMALE:									
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 2 ☐ Feta t at time of d	death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	olivery Day Year
<u>α</u>	res that igned b be deta	by P	Part II. Other significant condi	tions contributing to deat	h but not res	ulting in the un	derlying cause give	n in Part I.	236	e. Did tobacc	o use contribute t	to the cause of death?
rds	w require been sig should b		CitF							1 🗌 Yes	2 □ No 3 □ P	robabiy 4 🗆 Unknown
eco	law requas been 2 should	Completed	COPD						248	a. Was an		utopsy findings available
Œ		E O	Grenia						_	autopsy performed	death?	completion of cause of
/ita	ysician: This certificate	Be	25. Was case referred to medic examiner?	e referred to medical 26. Place of Death (Check only one)								
of	d is	2	1 Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatient	1000	4 (# INUISI			6 □Other (Spe	ecify)
Division of Vital Records,	Attending F r death. sctor: After by the funer	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pend		Day Year)	28b. Time of Injury	28c. Injury Work			scribe how in	jury occurred	
İSİ	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurre 28d.								and Number of C	lumi Dauta Alumban		
ă	al or after after Dire	building, etc. (Specify) Let Under the determined determined building, etc. (Specify)								ate)	urar noute trumber,	
	To the Hospital of within 24 hours af To the Funarel D completely filled in	27. Manner of Death								s stated. e to the cause(s)		
	To th To th comp	Me	29b. Signature and title of certifi	ier			29c. License	number		29d. [Date signed (Mon	th, Day, Year)
			burne 7	Clex ME				1395			9/13/07	
	·OX/		30. Name and address of perso	n who empleted cause o	f death (Item	23а) (Туре, Р	Print)				1	
	10		Wandy Kloesz	- no (701	N Chas	rint) US SI S	is, te	4202	10 Wsen	n red	21204
	Sta Registra		31. Date filed Month, Day, Yea. SEP 1	8 2007 32. egi	strar's Signa	ture	a R. B					
	## 17 Pay 1/20		SEP I	O ZUUT FAM	All S	i Maria						

07-07187 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Robert Frizzell Sellers 2007 29848 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ September 16, 2007 0147 hrs ROBERT FRIZZELL SELLERS **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign MARYLAND Months 220-36-6258 Director 5/12/1974 1X M 2 F 33 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Y Yes 2 No N/A MD BALTIMORE CITY notified at once. with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 527 HALF MILE COURT 21201 238 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married death Yes 2 X No Specify: BLACK Yes 2 X No specify: If Yes, Give Year t Pages 1 and 2 should be filed within 72 hours after riment of Health and Méntal Hygiene. retant: If item 27 is marked other than "natural", y or other traumatic event, the Merken Examiner. ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ROSEDALE 12TH ROOFER ROOFING COMPANY 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Physician** /Medical xaminer

s been signed by the att should be detached for s certificate has be rector, page 2 sh After this certific funeral director, [

Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner Completed by Be Certification: To Funeral Director: stely filled in by the **Jedical**

The factor of training (through through through							
ROBERT FRIZZELL SE	LLERS, I	II	CAF	ROLYN	JOHN	SON	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Addre	ss (Street and Nu	mber or Rura		ber, City or Town, Stat	
CAROLYN JOHNSON / M	OTHER	27 <u>35 W</u>	LAFAYE	TTE		BALTIMORI 2121	E 6 MD
20a. Method of Disposition		ce of Disposition (N			ate	20c. Location - City of	r Town, State
A		matory or other place $G \ \ MEM$. I	PARK	9/21	/07	WINDSOR	CM JJIM
4 Donation 5 Other Specify:							
21. Signature of Funeral Service Licensee	Now	4600	nd Address of Facili	HEI	GHTS 7	AVE, BALT	HOME 21207
23a Part Enter the lisease, or complications that enur. List only one cause on each line.	0	o not enter the mode	e of dying, such as	cardiac or re	spiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Immediate Cause (Final disease a. Multiple In or condition resulting in death)					_		10
5	a consequence of):		. 115				
Sequentially list conditions, . b	a consequence of):					_	1.
cause. Entur Underlying Cause							
(Disease or infliry that initiated	a consequence of):	-					
d							
UNPENDED AMENDED)						
23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnar e birth gnant at time of death nown	2 Fetal deat		ic pregnanc	y	23d. Date of delive Month	ny Day Year
Part II. Other significant conditions contributing	to death but not resu	ulting in the underlyi	ng cause given in F	Part I.	23e. Did to	bacco use contribute t	o the cause of death?
					1 Yes	2 ✔ No 3 Pr	obably 4 Unknown
					24a. Was a		autopsy findings available
					autops perfor		completion of cause of
					1 ✓ Yes 2		Yes 2 No
25. Was case referred to medical			26.Place of Death	n (Check onl	y one)		
examiner? 1 Ves 2 No Hospital: 1	Inpatient 2 🗸 El	R/Outpatient 3	DOA Other	Nursing I	tome 5	Residence 6 Oth	er:
27. Manner of Death 28a. Da		8b. Time of Injury	28c. Injury at Wor			now injury occurred	•
1 Natural 5 Pending Sep 1	6, 2007 0	100 hrs	1 Yes 2	No Di	river auto f	ixed object collis	ion
2 Accident Investigation	ace of Injury - At hom	e farm street facto	orv. office building.	etc. 28	Sf. Location (S	Street and Number or F	Rural Route Number, Cit
3 Suicide 6 Could not be	, ,		, y, sss banag,	int	or Town, St	tate) Baltimore, Md	
4 Homicide	y) Major Road /						
29a. Certifier 1 Certifying Physician: To the bone) 2 Medical Examiner: On the basi	est of my knowledge,	death occurred at t	the time, date and p	lace, and du	e to the cause	e(s) and manner as sta	ated. the cause(s)
one) 2 Medical Examiner: On the basi and manner					ie unie, udte a		
29b Signature and title of certifier		2	29c. License numbe	Г		29d. Date signed (M	lonth, Day, Year)
Man in Mills	Λ .		O.C.M.E.			September 16,	2007

Registra

State

To the

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2007

Margarita Korell MD.

31. Date filed (Month,

Assistant Medical Examiner

E SILLAGO

32 Registrar's Signature

07-06945 Kimberly Layrama	Please Type or Print in Black Indelible Ink. Ensur	e All Copies Are Legible.
Nimberry Layrania	Smith State of Maryland / Department of Health an 1- For State Certificate of Death	d Mental Hygiene
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day September 7, 2007 3. Time of Death 0708 hrs
(Location of Death 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Day	If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	Usual Residence of Decedent	July 23,1967 Country) Mb
ow any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 No
the Maryland as on 28a-f sh	10e. Street and Number 10f. Zip Code	. 10g. Citizen of What Country?
		Spanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
or items 2:		spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa	tion (Give kind of work done 16b Kind of Business/Industry
5-0036 ed within 72 hour sygiene other than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life	. DO NOT use retired)
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after not of Health and Meinal Hygiene unt. If item 27 is marked other than "matural", Ir other traumatic eyent, the Medical Examiner. To Be Completed by	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Malden Surname)
2121() 21	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	Marchella Hdd Son et and Number or Rural Route Number, City or Town, State, Zip Code;
ore, MD ss 1 and 2 sho of Health and If item 27 is ner traumati	Ida Swilling / grandmother 3439 Reister 20a. Method of Disposition (Name of ce	ntown Road Balthmore MD 21215
MOF6 Pages 1 ent of F	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	why 9/18/07 3 altimore, MD
Baltimo permit. Pag Department Important: injury or ot	21. Signature of Funeral Service Licensee 22. Name and Address	of Faglity Se Fineral Service P.A.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying,	such as cardiac or respiratory arrest; shock, or heart Approximate Interval
/Medical 'xaminer	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Between Onset and Death
<u> </u>	Sequentially list conditions, if any, leading to immediate	
red mist	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	the character of the control of the
in the contract of the contrac	d.	
760, cate be e physicia he burial	IF FEMALE: 23c. If yes, outcome of pregnancy	er MEO G-872 10/19/07 reb & Part II
Box 68760, to death certificate be eath attending physicial red for use as the buriar hysician/Medii	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Speciful)	Ectopic pregnancy Month Day Year
Records, P.O. Box 68760, The law requires that the death certificate be e cate has been signed by the attending physician page 2 should be detached for use as the burial completed by Physician/Medic	1 Yes 2 No 9 ✓ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I. 23e. Did tobacco use contribute to the cause of death?
S, P.(uires that n signed d be dett ed by	Cocaine Use	1 Yes 2 ✔ No 3 Probably 4 Unknown
Records, The law require ficate has been signage 2 should be Completed		24a. Was an autopsy findings available prior to completion of cause of death?
tal Reician: The certificate	25. Was case referred to medical 26.Place	1 ✓ Yes 2 No 1 ✓ Yes 2 No of Death (Check only one)
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death. In Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach ertification: To Be Completed by P.	1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other:
sion (ttending death. ctor: Af y the fun	1 Network (Montly Day Xear) 0:78 a.m.	y at Work? 28d. Describe how injury occurred unknown unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be eviltin 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial ledical Certification: To Be Completed by Physician/Medic	3 Suicide 6 X Could not be determined (Specify) Suicide Homicide 4 Homicide (Specify) House	uilding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1530 N. Broadway Baltimore, Md.
To the Host within 24 hd To the Fun completely	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, day one) Certifying Physician: To the best of my knowledge, death occurred at the time, day one) Medical Examiner: On the basis of examination and/or investigation, in my opinion,	te and place, and due to the cause(s) and manner as stated.
To viit To com	and manner stated. 29b. Signature and title of certifier 29c. License	
	30. Name and address of person who completed cause of death (Item 23a)	M.E. September 8, 2007
Ø	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201
State Registrar	31. Date filed Wenth, Play, Sear 2007 Registrar's Signature	

			For		State of Ma	aryland /	-			and Me	ental Hy	giene	Э		
_			1 - State Registrar				Cer	tificate of	Death			Reg. No	200	17	29850
	Physici	an	1. Decedent's Name (2	Date of De Month	Da	1 20 -	'ear	3. Time of Death
	/Medic		VERONICA								Septem		6 20		9.00 am
	Examin	er	4a. Facility Name (If no			13		4b. City, Town, o			_ `	40	. County of	Death	
		A.	5. Social Security Num		E of Ball	e (In yrs. last		If Under 1 Year	If Under		3. Date of Bir	th		9. Birthol	ace (State or Foreign
ь	Funeral Director		214-44-1		7	4	Yrs.	Months Days	Hours		3/02	/ 1°9	43 P	Count ENN:	SYLVANIA
	pu »		Usual Residence of Do	ecedent 0b. County		10c. City, T	own or Loc	ation						10	Od. Inside City Limits
	Maryla f shov led at	ō		BALTIMO	RE			MILLS							1 □Yes 2 No
	r 28a- notif	rec	10e. Street and Numb					10f. Zip Code			Т	10g. Ci	tizen of Wh	at Count	try?
	th with	Funeral Director	3440 ASS	SOCIATE	D WAY AF	т. 41			1117			US	Α		
	ems erms	nei	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. W	as Decedent of F Yes, specify Cub	lispanic Ori an, Mexicai	igin? (Speci n, Puerto R	ify Yes or No ican, etc.))-	 Race - Black, 	America White, e	
36	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F u	1 Never Married 3 □ Widowed 4		1	10		☐ Yes 2 No	Specify:				Specify:	WHI	ΓE
21215-0036	2 hour	ted t	1:	5. Decedent's Edu	ucation	1	6a. Deced	ent's Usual Occup	nation	et of working		16b. ł	Kind of Busi		
215	within 7 iene. than "n the Medi	Completed	Elementary/Second	only highest grad	College (1-4or 5	+)		aind of work done O NOT use retire					3313 (3)	DD 1	OT TIME THE
121	filed with Hygier that the		1 Z Y R S 17. Father's Name (Fit			I P	IANAG	SER-PLU			First, Middle	1			PLUMBING
Maryland	should be filed nd Mental Hygi marked other matic event, t	Be	EDWARD S								S SER		, comano,		
Z	2 should and Men is marke	ဥ	19a. Informant's Nam		vpe. Print)		19b. Mailin	Address (Street	1				or Town, St	tate, Zip	Code)
	nd 2 salth ar 27 is		JEROME S) 1	8222	PRETT	YBOY	DAM	RD.	PAR	KTON	, MD	. 21120.
re,	es 1 an of Heal fitem 2 rother		20a. Method of Dispos			20b. Place cem	e of Dispos etery, crem	ition (Name of eatory or other pla	ce)	Da	te	20c. L	ocation - C	ity or To	wn, State
Ē	Pages ment of l			Cremation 3 □1 □ Other (Specify,	Removal from State			OF FA		9/20/	/2007	ВА	LTO.	CO	.; MD.
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Fure	eral Service Licens	wall		HH	Name and Addre	JEN!	KINS	& SON	NS ,MD	CO.	111.	•
	38 2N		23a. Part1. Enter the shock, or heart	disease, or comp	lications that caused one cause on each lin	the death. [Approximate Interval Between
	Physician		Immediate Cause (Fir		-	epsie									Onset and Death 2 Day
	/Medical Examiner		resulting in death)		Due to (or as	a consequen	ce of):								-
	LAdimino	-	Sequentially list cond	litions,	b	a consequen	ce of):								
	uted I Insit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events	ring siury	(,									
ó	exect an and rial-tra	Еха	resulting in death) Las	st	Due to (or as	a consequen	ce of):			-					
68760,	icate be executed physician and s the burial-transit	edical		•	d										
	ng ph	Med	IF FEMALE:												
Вох	leath certific attending pl	ian/	23b. Was decedent p	regnant	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3 🗆	Ectopic pregnanc	у				23d. Date Mont		ry Day Year
P.O. I	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/M	1 Yes 2	No	4□Pregnant at 9□Unknown	time of deat	n 5∐	Other (specify) _							
	res that the de signed by the a be detached t	by Ph	Part II. Other significa	ant conditions	ontributing to death b	ut not resultin	g in the un	derlying cause giv	ven in Part I		23e. Did 1	tobacco	use contrib	ute to th	ne cause of death?
Vital Records,	quires en sign uld be		(0)	PD							1 🗆	Yes 2	2 □ No 3	☐ Prob	ably 4 √ Onknown
900	law requir as been s 2 should	Completed									24a. Was		24b. We	ere autop	psy findings available npletion of cause of
- B	The lay	E O									perfo 1□ Yes	ormed?	e de	ath2	2 No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred examiner?					1011		e of Death	(Check only	one)			
or/	Physic this cal dire	၉	1 Yes 2 √	0	Hospital: 1 Inpatie		Outpatient		4 🗆 Ni		e 5 ☐ Resi				y)
ou c	ding F J. Atter funera	ion:		5 Pending investigation	28a. Date of Inju (Month, Da		b. Time of Injury	28c. Inju Wo M 1 □	ryai rk? ∣Yes 2		3d. Describe	now inju	ary occurred	,	
Division	Atten death octor: yy the	fica	0 0 0.0.00	6 Could not be determined	Zoe. Flace of Illj	ury - At home	, farm, stre	et, factory, office		28				or Rura	I Route Number,
Ö	s after	Certification:	4 Homicide		building, et	ь. (эресіту)					City or To	wii, Sta	ie)		
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Atter the completely filled in by the funeral completely filled in by the funeral completely filled in the funer	Medical (rsician: To the best liner: On the basis o and manner st	f examination									
	within To th	Me	29b. Signature and tit	tle of certifier		_		29c. Licens					ate signed (
			1 She	awfulid	ü			RES	- 00	00		Sep	temb	46	2007
	V		30. Name and addres				Ba) (Type, F		2		0 4	1			
	Sta	to	31. Date filed (Month,	Day, Year)	3⊈. Registr	ar's Signatur	och	ai hos	pilal	- 01	'Soult	LE M	ose.		
	Regist		SEF	P 1 8 200	7 Staries	ar's Signature	BOOM								
					671		-	· · · · · · · · · · · · · · · · · · ·							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29852 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** David 5:30 PM Septemb. 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview medical Genter Baltinove 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e r items 2. 21222 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status "natural", or item 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: KOREAN Specify: White 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Office Manager

Office Manager

Office Manager College (1-4or 5+) Elementary/Secondary (0-12) Village Me nt of Health and Mental Hygis If item 27 is marked other or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is mar any Injury or other traumat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee dley-ASKION FUNERAL Home, PA, 2134 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metabolic Acidosis hours /Medical Due to (or as a consequence of) Examiner ntestinal Ischemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of). P.O. Box 68760, physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Day Month Year 5 ☐ Other (specify) been signed by the s should be detached I□Yes 2□No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 No this certificate or Attending Physician: funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2<mark>₩</mark> No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 TYes 2 TNo death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 VertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) KES-000 September 14,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

DR. Ashleigh

SEP 18

31. Date filed (Month, Day, Year)

HICKS

2007

32. Registrar's Signature

49:40 Eastern Avenue

Baltimore

MD

			State of State	Maryland	-	artment of I		Mental Hy	giene	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of De	Reg. No.2 0 0	7 29853
ı	Physic /Medi		SR M. Cany 1/19 S	on the	RS	M		Month	Day Yes	ar 730 D M
>	Exami		4a. Facility Name (If not institution, give street and nur	nber)	7(,).	4b. City, Town, o	r Location of Deat	h	4c. County of D	eath
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st hirthday)	Ba/h	MORE If Under 24 Hrs	. 8. Date of Bir		MORE
ľ	Funeral Director		163-16-8860 10M 200F	88	Yrs.	Months Days	Hours Min.		y, Year) 9	Birthplace (State or Foreign Country)
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c, City,	Town or Lo	cation		project	/ / /	10d. Inside City Limits
	Maryl a-f sho ifled a	tot	M) Baltimore	Ba	Ihmo	00				1 ☐ Yes 2 Mio
	or 28%	Director	10e. Street and Number		21/1/10	10f. Zip Code			10g. Citizen of What	Country?
	eath w is 23a must l	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S.	10.1	2/2 Was Decedent of H	12	<u> </u>	USA	
9	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		Armed For	ces? 2 TVNo	'	res, specify Cub	an Mexican, Puer	to Rican, etc.)	Black, W	merican Indian, hite, etc.
21215-0036	hours ural", al Exar	d by	3 Widowed 4 Divorced Year or Da	tes:		1 ☐ Yes 2 ☐ No			Specify: 4	Uhite
75	nin 72 n "nat Medică	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1		16a. Deced <i>(Give life. L</i>	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo d)	rking	16b. Kind of Busine	ss/Industry
	ed with /giene er tha t, the i	Com	Elementary/Secondary (0-12) College (1	40r 5+)		NURSO	•		Healthea	ile
and	f be file ntal H ed oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Surname)	. /
Maryland	2 should I and Meni Is marked	욘	19a. Informant's Name/Relationship (Type. Print)		19b, Mailin	a Address (Street	27RALE and Number or Ri	ural Route Number	ff <u>NU7</u> er, City or Town, State	Zin Code)
	1 and 2 Health a em 27 Is ther tra		Sisters of Mercy-Religi	cus der	1300	E. Nort	,	VKM211.	211	MD 21239
altimore,	S = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from S	20b. Plac	e of Disponetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location - City	or Town, State
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UNISION	Attencr death	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of the investigation	f injury - At home	, farm, stre		Yes 2 □ No	28f. Location (S	treet and Number or	Rural Route Number
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and manner.	is oi examination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2	Mec	one) and manne 29b. Signature and title of certifier	r stated.		29c. License	number	2	29d. Date signed (Mo	nth, Day, Year)
			man Solalouns Atta	nding Ph	1751'61	an I	26534		, ,	2007
	3	Ī	30. Name and address of person who completed cause	of death (Item 23	a) (Type, P	Print) - Drive	41			
	Sta		Mare Society MD 120, 31. Date filed (Month, Day, Year) 32. P	istrar's Signature	erre	- Wive	4105/1	JUN SOW	MU 212	.04
	Registra		SEP 1 8 2007	istrar's Signature	C P	osule)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 09 16 John B. Scott 2007 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8531 Stevenwood Road Windsor Mill
If Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1X M 2□ F 216-34-3745 Director 1-27-1936 MD Usual Residence of Decedent 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. inside City Limits MD Director Baltimore Randallstown 1 ☐ Yes 2√∑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3530 Resource Drive, Apt. 106 Funeral 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: African-American þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12th Raytheon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ John B. Scott Sr. Virginia Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Barnhill/Sister 8531 Stevenwood Road, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Garrison Forest Veterans 9-24-07 Owings Mills. MD 22. Name and Address of Facility Wylie F/ H P.A. of Balto. Co. 21. Sature of Funeral Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** metastati disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1□ Yes ZDA No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SISTO'S HOME 2 ER/Outpatient 3 DOA 1 | Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1/2 Natural Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

arole 31. Date filed (Month, Day, Year) 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. NZ 0 0 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 09 2007 7:00 A 13 Sarah Stevens /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3918 Edmondson Avenue Baltimore ff Under 1 Year | ff Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 20 F 76 Yrs. 219-28-8464 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f ehow or other traumatic event, the Madical Examiner must be nutified at 1 Tx Yes 2 □ No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 within 72 hours after deeth with USA 3918 Edmondson Avenue Iteme 23a 21229 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No !! Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes XX No SpecifAfrican American Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Etementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Depertment of Health and Mental Hygien Importent: if Item 21 is marked other that any Injury or other treumatic avent housekeeping 8 homes 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Gerturde Matthews James Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie Mae Stevens / sister-in-law 3918 Edmondson Avenue; Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/19/2007 Mount Zion Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funer L Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pulnay Dropo certificate be executed burial-transit Exam Due to (or as Box 68760, the attending physicien Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 ☐ Probably 4 🗗 Unknown 1 ☐ Yes 2 ☐ No Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? certificete 1 Yes 2 10 No : After this certifice stuneral director. p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 Yes 2 No 2 FR/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: fnjury Attending 1 Natural 5 Pending To the Hospitel or Attendir within 24 hours after death.
To the Funerel Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fourtoud, BOLTIMORE 4419 MD 2/2/1 mr 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			for State	State of Ma	ryland /					al Hygie	ne	
	_	4	Registrar 1. Decedent's Name (First, Middle, L	994)		Cert	ificate of	Death			No.2007	29856
¥,	Physici /Medic		Charles E.	Shutt					I м	ate of Death Ionth otembe	Day Year 200	3. Time of Death 7 2:45 A M
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B	Funeral Director			Sex 7.Age 11√∑M 2 ☐ F	(In yrs. last I	birthday) _ Yrs.	If Under 1 Year Months Days			ate of Birth fonth, Day, Ye		thplace (State or Foreign ountry)
<i>*</i>			489-12-1423 Usual Residence of Decedent		00				Apı	ril 10	, 1921 Mis	souri
	inylan ihow I at		10a. State 10b. County		10c. City, To	wn or Loca	ation					10d. Inside City Limits
	8a-f s	Director	Maryland Montgon	nery	Chev	y_Cha	se					1 ☐ Yes 2🎇 No
	a or 2 be n	Ö	10e. Street and Number				10f. Zip Code				Citizen of What Co	,
	heath	eral	8100 Connecticut	Avenue, Apt			208		gin? (Specify V		ited Stat	
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Maryland 21215-0036	d be fi	Be	17. Father's Name (First, Middle, Las Russell Shutt	t)				18. Mothe	r's Name <i>(First</i> Dodd	, Middle, Mai	den Surname)	
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	1 _ State	and / Department of Health and M Certificate of Death	2007 2005
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Examiner	4a. Facility Name (If not institution, give street and number) Ste I a Mac is	4b. City, Town, or Location of Death	4c. County of Death
Funeral		rrs. last birthday) If Under 1 Year If Under 24 Prs. Yrs. Months Days Hours Min.	B. Date of Birth Month, Day, Year) Country Country
Director	Usual Residence of Decedent	99 118.	11.25-22 S. Carolina
farylan show		City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
or 28a-	10e. Street and Number	20-1+imore 10f. Zip Code	10g. Citizen of What Country?
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Arary 12 shou 1 and M 1 is mai	19a. Informant's Name/Relationship (Type. Criff) xue she	19b. Mailing Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)
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quires t quires t and be c		estiting in the underlying cause given in Part i.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
0 25 0	1		24a. Was an autopsy available prior to completion of cause of
The ficate h			autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ▼ No 1 ☐ Yes 2 ☐ No
hysiciar this certif al directo	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	26. Place of Death ☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Hor	(Check only one) me 5 ☐ Residence 6 ☐ Other (Specify) HOSPICE
ing Ph Affer th uneral	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day Year)	28b. Time of 28c. Injury at 28 Work?	28d. Describe how injury occurred
tal or Attending is after death. all Director: After led in by the funer. Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 ☐ Yes 2 ☐ No home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
ital or after ral Direction the continuation of the continuation o	building, etc. (Spe	(City)	City or Town, State)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k	mowledge, death occurred at the time, date and place, a ination and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
To the complete Complete Me	29b. Signature and tile of certifier	29c. License number	29d. Date signed (Month, Day, Year)
(100	243725	9/14/07
H	30. Name and address of person who completed cause of death (It DR. TARIQ MAHMOOD 2300 DULA	NEY VALLEY RD. TIMONTHM	MD 21093
State	31. Date filed (Month, Day, Year) 32. Fishrar's Sig	mature Sparks	لال
Registrar	SEP 1 0 2001 Person	J. Boards	

			1 - State of I	Maryland / Dep <i>Ce</i>	artment of F rtificate of		ental Hygier ۱. _{Reg.} ا	2007	29858
	Physici	an	1. Decedent's Name (First, Middle, Last)	7 T F117	CHORMAN	/IID	2. Date of Death	Day Year	3. Time of Death
Mary.	/Medic	al	DAVID 4a. Facility Name (If not institution, give street and number)	ALLEN		KER, SR.		4, 2007 tc. County of Deat	
	LXaiiiii	À.	144 East Main St., AP	,	WEST	MINSTER		CARROL	
	Funeral Director		212-48-4812 ¹ 反M 2□F	Age (In yrs. last birthday) 58 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 2 / 1 2 / 1 9	ur) Co	hplace (State or Foreign untry) LYLAND
	yland now at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar Sa-f sh tiffied	Director	MD CARROLL	WESTMIN	STER				1X∏Yes 2∐No
	with th		10e. Street and Number		10f. Zip Code			Citizen of What Co	untry?
	ms 23	Funeral	144 EAST MAIN ST., A 11. Marital Status 12. Was Decede		Was Decedent of H	57 lispanic Origin? (Spe an, Mexican, Puerto I		JSA 14. Race - Ame	rican Indian,
9	or ite	y Fui	Armed Force 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 [If Yes, Give	□No	1 ☐ Yes, specify Cub	an, Mexican, Puerto F Specify:	Rican, etc.)	Black, White	•
5-0036	hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Date:		dent's Usual Occup		16h	Specify: WH:	
215	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c	(Give		during most of working	ng	Tallo of Basilless/	muusty
12121		S	12 2	. 1	ERVICE				SYSTEMS
and	ev d tal	To Be	WILBERT	SHOEMAKER	, SR.		(First, Middle, Maide ETERSON	en Surname)	
Maryland	s 1 and 2 should if Health and Men Item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number, City	or Town, State, 2	Zip Code)
	1 and 1 Health em 27 ther tr		MARCELLA SHOEMAKER - V	VIFE 144	E. MAIN	ST., APT			MD 21157
nor	00		1 ☐ Burial 2 【Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te cemetery, cre	matory or other plac	ce)		Location - City or	,
altimore,	permit. Pag Department Important: I any Injury o		21. Signatur Frank Strice Licensee	ALL COUN					HOME, P.A.
m m	8 a a a			2	254 E. M	IAIN ST.,	WESTMI		
Z	Dharistan		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each immediate Cause (Final	ed the death. Do not en	ter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	as a consequence of):	at Ca	h C ex			
	Examiner	L	Sequentially list conditions. b						
/	nsit	Examiner	cause. Enter Underlying	as a consequence of):					
o O	executed an and rial-transit		that initiated events resulting in death) Last C. Due to (or a	as a consequence of):					
98760	ficate be execute physician and is the burial-trans	edical	d						
Box 6	death certific attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome the second se					23d. Date of deli	ivery
	The law requires that the death certi te has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months?	at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
J.	uires that the de I signed by the a Id be detached f		9 ☐ Unknown Part II. Other significant conditions contributing to death		nderlying cause giv	en in Part I	23e Did tohacco	use contribute to	the cause of death?
rds,	quires n signe	d by	None Known						obably 4 donknown
Hecords,	ne law requir has been si ge 2 should b	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
T T		S					performed? 1□ Yes 2 2	death?	2 □ No
Vital	Physician; Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa	tient 2 ☐ ER/Outpatier	ot 3 DOA Oth	26. Place of Death	(Check only one)		
0	ding Phys h. After this funeral dir	- 1	27. Manner of Death 1 Natural 5 Pending (Month, L	njury 28b. Time o			8d. Describe how inj		cify)
UIVISION	or Attending ifter death. Director: Afte in by the fune	catic	2 Accident investigation	njury - At home, farm, str	M 1 🗆	Yes 2 □ No			
2	al or Attend after death I Director;	Certification:	4 Homicide determined building,	etc. (Specify)	eet, factory, office	2	8f. Location (Street a City or Town, Sta	and Number or Hu ite)	rai Houte Number,
	To the Hospital or within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner	of examination and/or in	h occurred at the tir vestigation, in my c	ne, date and place, a pinion, death occurre	nd due to the cause ad at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 3	Mec	29b. Signature and title of certifier	stated.	29c. Licens			ate signed (Month	n, Day, Year)
L	11		I toward Sowiet, u	· .		222	9	3/14/07	
Û	1		30. Name and address of person who completed cause of Howard Jaiontz, m.D.	CC5 1 C0	Lter (treet 6	Jestinins	ter mo	1. 21157
\$ E	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 8 2007	trar's Signature	eparts				

		Please Type or Print in Black Indelible Ink. Ensure All			
		State of Maryland / Department of Health and M	ental Hy	giene	
	-	State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. No. 200	7 29859
Physic /Med		HELEN EMILY STENABAUGH	Month SEPT.	Day Yea	
Exam	iner	4a. Facility Name (If not institution, give street and number) CARROLL HOSPICE DOVE HOUSE 4b. City, Town, or Location of Death WESTMINSTER		4c. County of Do	eath
Funera Directo		5. Social Security Number 6. Sex 1 5 4 - 1 2 - 9 6 4 3 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birtl (Month, Day	h 9. E	Birthplace (State or Foreign Country)
D T		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	8/13/	1918 NE	
e Marylı ka-f sho tified at	ctor	MD CARROLL WESTMINSTER			10d. Inside City Limits 1 Yes 2 No
3a or 28	al Director	10e. Street and Number 102 TIMBER RIDGE DR., APT. 113 21157		10g. Citizen of What	Country?
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sperific Yes, specify Cuban, Mexican, Puerto Forces)	cify Yes or No-	14. Race - Ar	nerican Indian,
21213-90036 Within 72 hours after death with the Maryland jiene. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify:	ricari, etc.)	Specific	hite, etc. HITE
15-0036 72 hours af "natural", or	Completed	15. Decedent's Education (Specify only highest grade completed) Florentany(Secondary (0.12) Callege (1.4.4.5.5.) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g I	16b. Kind of Busines	
d within 72 giene.	dmo;	Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE		номе ма	KER
and Z and Z d be filed ental Hygi ced other c event, II	Be	17. Father's Name (First, Middle, Last) ALBERT PHILLIPS SARA		, , , , , , , , , , , , , , , , , , , ,	
Tarylan 2 should be and Menta Is marked aumatic ev	2	Shirt-		WILS	
≥ 5 € 5 €		19a. Informant's Name/Relationship (Type. Print) CAROL ANN EDWARDS -DAUGHTER 3080 DEEP VALLEY D	Houte Numbe	r, City or Town, State	^{2, Zip Code} 21157
0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	ate	20c. Location - City	or Town, State
등학육 : 〓		4 Donation 5 Other (Specify) LAKE VIEW MEM.PARK 9/18/	07 1	ELDERSBU	RG, MD
permi permi Depar Impor any Ir		21. Signature of Fundamental Service Licensee 22. Name and Address of Facility FLET 254 E. MAIN ST.,	ICHER WESTM	FUNERAL INSTER.M	HOME, P.A.
		23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, wheat failure. List only one cause on each line.	respiratory arr	rest,	Approximate Interval Between
Physician /Medical	ı	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequer ce.) fix	1		Onset and Death
Examiner		Same 11 - 10 - 11	Q		(onus)
Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):			one
ficate b	edica	d			
th certifications and inserting	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	elivery
The law requires that the death certificate be ate has been signed by the attending physicial agge 2 should be detached for use as the bur	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Other (specify) 9 Unknown		Month	Day Year
w requires that the deben signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
requires t			1 🗆 Ye	es 2MNo 3□	Probably 4 Unknown
rictor, page 2 s	Completed		24a. Was a autops perforr	sy prior to	autopsy findings available completion of cause of
	Be C	25. Was case referred to medical examiner? 26. Place of Death	1□ Yes : Check only on		es 2 No
ding Physician: The Indian After this certificate he funeral director, page	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom			ecify)HOSPICE
ath. r: Aftel	ation	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No	d. Describe ho	w injury occurred	
or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 1 ☐ Could not be determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (St City or Town	reet and Number or I n, State)	Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, ar	nd due to the ca	ause(s) and manner	as stated.
the Ho hin 24 the Fu	Medical	one) Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, d	ate and place, and di	ue to the cause(s)
T wit		29b. Signature and title of certifier 29c. License number		9d. Date signed (Moi	
•		30. Name and address of person who completed cause of death (flem 23a) (Type, Pont)		477.11	h, 2007
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1207	westoul	E MARIE
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			,
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has After this

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

death.

after death

e Funeral I

within 24

Medical

State Registrar

Be 2 Certification:

1 🗌 Yes

27. Marmer of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

25. Was case referred to medical examiner?

2 No

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

2 No 1□ Yes 26. Place of Death (Check only one) 5 ☐ Residence 6 XIOther (Specify) HOSPICE

Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defining rigidiant to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number D3166C

STONER AVENUE

29d. Date signed (Month, Day, Year) 12007

WESTMINSTER MAULIAGE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trames K. Galves Til

291 MEMAS K. MUNE 111 MO

5 Pending investigation

6 Could not be determined

■egistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fth 871 9-18-07 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Month Year BLANCHE SAMUELS /Medical SEPTEMBER 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON

If Under 1 Year | If Under 24 Hrs. BALTIMORE 8. Date of Birth (Month, Day, Year, 04/28/1926 Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 1□M 2【**X**F Months Days 81 Director NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits notified at Funeral Director MD N/A 1 ☐ Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 6307 GREENSPRING AVENUE 21209 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN HOME traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN GALOWITZ ပ SARAH UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL SAMUELS / SON 13603 DIAMOND HEAD DRIVE - TAMPA, FL. 33624 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARLINGTON CHIZUK 09/17/2007 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of); sician and burial-transit certificate be executed or Vital Records, P.O. Box 68760,ලි Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 5 3 ☐Ectopic pregnancy in the past 12 months? Year 4□Pregnant at time of death Month Day Yes ed by the a detached f 5 Other (specify) 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 2 certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) HOSACC 1 ☐ Yes 2 No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) D64395 SEPTEMBER 14, 2007

State Registrar 6565 N CHAPLES ST, SUITE 216 BALTIMERE, MO 21204

person who completed cause of death (Item 23a) (Type, Print)

MA

DANIEUE DOBERMAN,

Year)

31. Date filed (Month, Day,"

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aniend of Kan 19a Per fth 8871 9-18-07 Wental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 11 2007 Physician KATHERINE SHULMAN /Medical 9:45A 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dav. Year) 1 □ M 2 🛣 F Days halman Kathering 9/11/07 Months Hours Director 217-20-3058 81 03/22/1926 **CUBA** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notifled at 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3601 CLARKS LANE, #407 Funeral 21215 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 X Yes 2 No Specify: CUBAN Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) AMERICAN NATIONAL and 2 should be filed within ealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CAN CORPORATION SECRETARY 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce. MORRIS 2 SHULMAN MANYA 10a Informant's Name/Relationship REPRESENTATIVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 OLD COURT ROAD, SUITE 7, BALTIMORE, MD 20b. Place of Disposition (Name of MOSES MONATOR FOR PLACE) WOODMOOR HEBREW COI 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CONG. 09/16/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service License SOL LEVINSON & BROS., INC. remix 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ridney **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No tensin 00 1∐ Yes 25. Was ca e ferred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 No Other: 4 \sum Nursing Home Certification: To 1 ☐ Yes 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

the Hospital or Attending Physician: The law requires that the death certificate be executed find.24 hours after death. The Law Attended to the certificate has been signed by the attending physician and repletely filled in by the funeral Director: After this certificate has been signed by the attending physician are mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, To the Hosp within 24 hot To the Fune completely fi

> State Registrar

DHMH 17 Rev 1/2001

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Year) 31. Date filed (Month, Day,

29b. Signature and title of certifier

(Check only one)



Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State of IVI	aryland / Depa <i>Ce</i>	artment of He rtificate of D	ealth and M <i>leath</i>	ental Hygi Re	ene g. No. 2007	29863		
	Physic		1. Decedent's Name (First, Middle, Last)				Date of Death	er 14 2007	3. Time of Death		
	/Medi Exami		Fenner Cleveland Swar 4a. Facility Name (If not institution, give street and number)	mier	4b. City, Town, or L		septembe	4c. County of Dea			
	EXAIIII	iei	Brighton Gardens		Colur			,	ward		
	Funeral	1		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth				
E	Director		237-24-7844 1⊠M 2□F	89 Yrs.	Months Days	Hours Min.	(Month, Day, August 17		hplace (State or Foreign nuntry) n Carolina		
	yland Jow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ecation				10d. Inside City Limits		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Director	Maryland Howard	Laurel					1 □ Yes 2 X □ No		
	ith th or 28	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?		
	ath v s 23a nust		10623 Glen Hannah Drive		20723			JSA			
	er de items ner n	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hisp if Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
36	ırs aftı Il', or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		Specify:		Specify	nite		
9	2 hou natura ical E	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupati	ion	11	6b. Kind of Business/			
Maryland 21215-0036	thin 7 le. ian "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	+) (Give life.	kind of work done du DO NOT use retired)	ring most of workin	ig .		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
21	led wi lygier her th	S	12	Firefig				U.S. Govt.			
anc	The state of the s										
Ž	should be and Mental is marked o	Grover Cleveland Reynolds Isavene Rolin									
	nd 2 safth ar 27 is r trau			1					(ip Code)		
Ē,	20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fungeral Service Licensee 22. Name and Address of Facility								Town, State		
<u>m</u>											
3alt									Tana		
	205 2		7601 Sandy Spring Road, Laurel, Maryland 207								
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between		
	Physician /Medical		resulting in death)	er's Dementia	1				Onset and Death 10 Years		
	Examiner			a consequence of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	a consequence of):							
1	ecuted nd ransit	Examiner	that initiated events								
30,	be executed ician and burial-transit	E	resulting in death) Last Due to (or as a	a consequence of):							
68760,	tificate be executed ig physician and as the burial-transit	edical	d								
Box 6			IF FEMALE: 23c. if yes, outcome 23c. if yes, outcome	of pregnancy				201 P. 1. (18)			
	death cerl e attendin d for use a	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	2 □ Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year		
P.0	that the de led by the a detached t	Physician/M	9□Unknown 9□Unknown								
	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contributing to death bu	t not resulting in the un	derlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
ord	requir een si nould	ted	Anemia				1 ☐ Yes	2∭ No 3☐ Pro	bably 4 Unknown		
Records,	e la has	Completed by					24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of		
a	Th ate pag		05 Was asset of		·		performe 1□ Yes 2	d? death? ☐No 1☐Yes	2 □ No		
Vital	Physician: this certific	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No Hospital: 1 ☐ Inpatier	0.5550/0.4	045	6. Place of Death					
0	g Phy er this eral d	2 : 1 ₀	27. Manner of Death 28a. Date of Injur		28c. Injury a Work?	4 Nursing Hom	e 5 Residence Bd. Describe how	ce 6 COther (Specinium occurred	ify) Assisted Living		
ion	Attending r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury		s 2 □ No		myary coodinou	LIVING		
Division or	ir Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of inju	ry - At home, farm, stre . <i>(Specify)</i>	et, factory, office	28	Bf. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,		
Q	ital o							,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1	examinati <i>o</i> n and/or inv	occurred at the time, estigation, in my opin	date and place, ar ion, death occurre	nd due to the cau	se(s) and manner as e and place, and due	stated. to the cause(s)		
	To the within To the Control	ĕ ⊠	29b. Signature and title of certifier	_	29c. License n	umber	29d	. Date signed (Month	, Day, Year)		
			· M	M.D.	D0056531						
	m	-	30. Name and address of person who completed cause of de	ath (Item 23a) (Type, F				eptember 14	, 2007		
	10		Harry Li, 8600 Snowden River		, Columbia,	Maryland	21045				
	Sta Registra		31. Date filed (Month, Day, Year) 32. Resetra	's Signature	meli						

		•	1 - For Amend Item 24a per verb., 9571,0971	8/0 Cer	ord Beath and Mental Hygiene 2007 29864							
	1	- R	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death							
	Physici /Medic	_	Erroll Taylor September 2, 2007 8									
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death 4c. County of Death							
	-64	XV.	Washington Adventist Hospital		Takoma Park Montgomery							
de la	Funeral Director		244-78-3476 37	rs.	Months Days Hours Min. (Month, Day, Year) Country) 1111K							
	aryland show	_	Usual Residence of Decedent 10a. State unk 10b. County unk 10c. City, Town	or Lo	Location unk 10d. Inside City Limits unk 1 ☐ Yes 2 ☐ No							
	vith the Mi	Director	10e. Street and Number U	ınk								
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-f ehow other traumatic event, I'm Mudical Exam or main the myllied at	by Funeral	11. Marital Status unk 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.Sunk Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	11	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: black							
21215-0036	thin 72 hours enatural Medicul E.	Completed t	15. Decedent's Education (Specify only highest grade completed)	(Give	cedent's Usual Occupation verkind of work done during most of working b. DO NOT use retired) unk 16b. Kind of Business/Industry unk							
ind 21	12 should be filed within h and Mental Hygiene. 7 ie marked other then "raumatic event, I'm Mer	Be	unk 17. Father's Name (First, Middle, Last)		unk 18. Mother's Name (First, Middle, Maiden Sumame) unk							
Maryland	2 should and Men ie marke aumatic	2	19a. Informant's Name/Relationship (Type, Print) . 19b.	Mailin	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
altimore, N	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of cemetery	Dispo	OO Carroll Avenue Takoma Park, MD 20912 Sposition (Name of rematory or other place) Date Date 20c. Location - City or Town, State							
Baltir	4 Donation 5 Mother (Specify) in state 21. Signature of Superal Signature of Superal Signature of Signature											
1 5.5	Physician		23a. Pal 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ot enti	Approximate Interval Between Onset and Death							
	/Medical Examiner	_	resulting in death) Due to (or as a consequence of Sequentially list conditions, b.									
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen									
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		3 ☐Ectopic pregnancy 23d. Date of delivery 5 ☐ Other (specify) Month Day Year							
	sign d be	ρ	Part II. Other significant conditions contributing to death but not resulting in	the ur	e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown							
Il Records,		Completed			24a. Was an autopsy performed? 1 Yes XNo 1 Yes 2 No							
/ita	nysician: T	Be	25. Was case referred to medical examiner?		26. Place of Death (Check only one)							
	ding Phys h. After this funeral di	tion: To	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Out 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation Hospital: 1 ☑ Inpatient 2 ☐ ER/Out 28a. Date of Injury (Month, Day Year) 28b. Ti	_	e of 28c. Injury at 28d. Describe how injury occurred							
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, str	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, (Check only one) and manner stated.	death	path occurred at the time, date and place, and due to the cause(s) and manner as stated. Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
	To the within To the comp	Me	29b. Signature and title of certifier	>	29c. License number Dy TCC 29d. Date signed (Month, Day, Year) 9-U-07 De, Print), (W. 124) BCCIE TD 20 717							
			30. Name and address of person who completed cause of deeth (Item 29a) C	Турө,	ex CN, 124 Bocie MD 20 71T							
10	Sta Registi	_	31. Date filed (Month, Day, Year) SFP 1 8 2007 32. Registrar's Signature	all.								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13, 2007Day Month **Physician** 11:40 AM September Stuart Oswald Thompson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard 14498 Triadelphia Mill Road Dayton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□F 578-05-2469 96 1911 West Virginia Director 30. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentlal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he marified as 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2XNo Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11812 Greenleaf Avenue 20854 United States Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White <u>^</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles W. Thompson Marguerite Martin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 200 River Beach Drive, Ormond Beach, FL 32176 Robert C. Thompson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) September 20c. Location - City or Town, State 20a. Method of Disposition y Crematorium 15, 2007 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.

Bethesda, Maryland 20814-3501 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 21. Signature of Funeral Service Ligensee M01473 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) **Physician** 3 Months Esophageal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events reculting in death). Due to (or as a consequence of): Examine burial-transi and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 4□ Nursing Home 5□ Residence 6 ⑤Other (Specify)Residence Other: Hospital: 1 Yes 2 ER/Outpatient 3 DOA 2 № No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation or Attending 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after 1 🗶 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M044580 September 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9711 Medical Center Drive, #308, Rockville, Maryland 20850 Mark Gloger, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar

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Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Fyamina.

Physician /Medical **Examiner**

burial-tran Division or Vital Records, P.O. Box 68760, physician the attending pt for use as the ed by the a signed t certificate has been si rector, page 2 should funeral director, this After t death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f.

þ Completed Be **ISRAEL** 2 23a. Part1. Ei shock, q Examine Physician/Medical IF FEMALE: 9 Unknown \$ Completed Be Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide 29a. Certifier Medical (Check only

1 - For State Registral 1. Decedent's Name (First, Middle, Last) **Physician** Ruth 2007 Vurner September 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore City 2710 JENNER DRIVE APT. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/09/1919 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗶 F 88 220-07-4705 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits MD N/A BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2710 JENNER DRIVE APT. E 21209 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND COURT ADMINISTRATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **FLEISCHER** SARAH **SCHWARTZ** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>MEREDITH KEMP / GRANDDAUGHTER</u> 6821 MANDALAY COURT - GAINESVILLE, VA. 20155 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI TFILOH CONG. 09/16/2007 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Licens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardisvascular Years Due to (or as a consequence of) Hypertention
Out of or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO September 14 2007 328 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rundallstown MO Koggen 5400 Old Court Road Suite 108 31. Date filed (Month, Day, Year) **B**gistrar's Signature 8

12

State

Registrar

known as washington, Charles Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #29c Per phy C871 9/18/07 Jh Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Sylvester Year WashingTon nar € 5 /Medical September 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE CITY SINAL HOSTITAL OF BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 215-60-0165 1**X** M 2□ F Months Days Hours Min. 55 Yrs. Director June 1, 1952 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Marylanc and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Director Md. Baltimore 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3022 Grantley Avenue U.S.A. 21215 Funeral Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married jo. 1 ☐ Yes 2 No Specify: Black Specify: þ 3 Widowed 4 Divorced "natural" Completed or than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 6 item 27 is marked other other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Charles Washington pedden Hilda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3022 Grantley Avenue, Baltimore, Md. 21215 permit. Pages 1 and 2:
Department of Health at
Important: If item 27 Is
any injury or other trau Patricia Washington wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/2007 Baltimore, Maryland oudon Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility The Derrick C. Jones Funeral Home, 4611 ParkHeights Ave. Baltimore, Md. 21215 23a. Part1. Enter the disease, or complications has caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 days INTRACEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner INFECTIOUS ENDOCARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit the death certificate be executed RESPIRATORY FAILBRE Due to (or as a consequence of): attending physician for use as the buria Physician/Medical renal tailure as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Dav Year 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient completely filled in by the funeral dir ၉ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred Attending 1X Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vanadaun, MD 09/14/2007 Res-000

State Registrar

DHMH 17 Rev 1/2001

ANAO

31. Date filed (Month, Day, Year)

SEP

PAUNI

1 8 2007

- Baltimore

Sinai Hospital

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

			1- For State of Maryland / Department of Health and Mental Hygien 2 007 2986	58
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	
	/Medio Examir		Mary Lee White 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ellicott City Nursing and Rehab 4c. County of Death Howard	- 14
-nath	Funeral Director		5. Social Security Number 215-24-7936 6. Sex 1 Months Days Hours Min. April 8, 1923 West Virgini	oreign
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li	
	the Mary 28a-f sh potified	Director	MD Howard Elkridge	
	ath with \$ 23a or nust be r	ral Dir	6391 Rowanberry Drive Apt 421 21075 U.S.A.	
2-0036	be filed within 72 hours after death with the Maryland that lygiene. Adother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1	
7	d within 72 h giene. er than "natu the Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator 16b. Kind of Business/Industry Production	
Maryland 2121	ges 1 and 2 should be filed w t of Health and Mental Hygier If Item 27 Is marked other tt or other traumatic event, the	To Be C	17. Father's Name (First, Middle, Last) Melvin Brewer 18. Mother's Name (First, Middle, Maiden Surname) Louedyth Coldiron	
, Mar	and 2 sho ealth and m 27 Is ma	80	19a. Informant's Name/Relationship (Type. Print) Cecil J. White/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6391 Rowanberry Drive Apt 421 Elkridge MD 21075	
altimore,	permit. Pages 1 Department of H Important: If Itel any Injury or ott	,	20a. Method of Disposition 20b. Place of Disposition (Name of Carbetery, crematory or other place) 3 Removal from State 4 Ponation - Other (Specify) 20b. Place of Disposition (Name of Carbetery, crematory or other place) Clen Haven Memorial 9-18-2007 Glen Burnie, MD	
Ra	Depa Impo any l	1	21. Significantly Fundal Service Lie 22 Name and Address of Facility Home of Lansdowne Authorose Funeral Home of Lansdowne MD 21227	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Onset and Death	n th
	Examiner	J.	Severe Pendonal Mangular DIRean	
oʻ	ficate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence or). Coronary Artery De Ferrer. Due to (or as a consequence of):	
	tificate bu g physici as the bu	edical	d	
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1	
ecords, P.	equires that en signed by ould be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4	
al necc	i: The law ricate has be	Completed	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	lable of
1 A 1	hysiciar his certif I directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	
SION OF	nding P tth. r: After t e funera		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No	
	al or Atte	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		g	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
1	To To	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 14 200	2
4			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rames h Sahanathi 201-105 Back River Neck Road Batternex Mayland	1
	Stat Registra	e ir	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rames h Sabanalhi 201-105 Rack Ruch Meck Nood Kalternax Mayland 31. Date filed (Month, Day, Year) SEP 18 2007 32Aegistrar's Signature 33Aegistrar's Signature SEP 18 2007	ect.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29869 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^D34, 2007 September **Physician** 6:17 P M Paul Clayton Willinger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Berlin
If Under 1 Year If Under 24 Hrs. Atlantic General Hospital 8. Date of Birth 08-24-1926 7. Age (In yrs. last birthday) 81 Yrs 9. Birthplace (State or Foreign Sex 1X M 2□ F **Funeral** Months Days Hours Mary l'and Yrs. 219-22-2707 Usual Residence of Decedent Director 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☑ Yes 2 ☐ No Director Selbyville Sussex Delaware 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 19975 38701 Yolanda Street 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: WW∐ 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Appliances **HVAC** 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marion V. Sheedy Christian J. Willinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen May Willinger - Wife Chuchville, Maryland 21028 200 Calvary Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State Sykesville, Maryland Lake View Memorial Park 09/19/2007 4 □Donation 5 □ Other (Specify) 5305 Harrford Road 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. Approximate Interval Between Qnset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** arunduna 2003 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 2□ No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signa

Registrar

31. Date filed (Month, Day, Year) 18 2007



Heghway

Famuete Folcerel De 19944

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1607 September 13, 2007 obent /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Be hesapente 7. Age (In yrs. last birthday) Air Harfor per If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 □ F Months Days Hours Min. 64 19-38-3452 40905+24,1943 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State a or 28a-f show t be notified at 10b. County 1 Yes 2 No Director MD Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA "natural", or Items 23a magnolia by Funeral the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SelF arpenter Department of Health and Mental Hygir Important: If item 27 is marked other injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Baltimore, Maryland Be pe White Swinson ပ Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1628 Furnace Drive Glem Burnie MD 21060 Danald 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Veremation Date Pages ' Bay view Crematon 10% 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hari P. Cluse Funeral Service, Hari MD 21206 Road Belair 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
MONTHS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical detached for use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown cate has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 25 No 1 npatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesa peat Maria 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

White Rober

			State of Maryland / Del 1- State Amend #8, perFD, g871, 9/26/07 TT Co	partment of Health and Men ertificate of Death	tal Hygiene Reg. No	1007	29871
	Physici		1. Decedent's Name (First, Middle, Last) SHAUN	2. [Date of Death Month Day		3. Time of Death 2149 M
	/Medic Examin Funeral		4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death BACTIMORE CI	Ac. Date of Birth Month, Day, Year)	. County of Death	place (State or Foreign
	Director		217-86-096+ 1 □ M 2 □ F 37 Yrs. Usual Residence of Decedent	A	ori 22, th	70 M	aryland
	ith the Marylan or 28a-f show o notified at	ctor	Mandand 10b. County 10c. City, Town or	Baltimore 101. Zip Code 21216			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 4204 Duvall Ave.	7.4		tizen of What Cou	4
036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show he Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical 1 ☐ Yes 2 ☐ No Specify: 	Yes or No- n, etc.)	14. Race - Ameri Black, White, Specify: Blog	
21215-0036	I within 72 ho iene. r than "natur the Medical.	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired) Postal Clerk	16b. K	ind of Business/Ir Intel Sta Postal S	ates enice
	uld be filed fental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Rodney Wilson	18. Mother's Name (Fir Staphani			
, Maryland	and 2 shou lalth and M 27 is mar ar traumat		19a. Informant's Nam Pelationship (Type, Print) Penny WISon - wife 42	ailing Address (Street and Number or Rural Ro 04 Dwall Ave. B	attimere	Maryle	and e
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dep: riment of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 shov any injury or other traumatic event, the Medical Examinar must be notified at Once.		1 Burial 2 Cremation 3 Removal from State	sposition (Name of page) Personal Park 22. Name and Address of Facility Parker	107 Ran	dallston	own, State on Maryland 11229
Ba	Dep Impo			3572 Frederick Ave	BaHi.	more, Mai	Approximate
	Physician /Medical Examiner	_	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions,	LIVER DISEASE			Interval Between Onset and Death 48 Hours
8760, U	cate be ex cater physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				10 years
P.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	very Day Year
	juires that n signed b ild be deta	Ď	Part II. Other significent conditions contributing to death but not resulting in the	e underlying cause given in Part I.			the cause of death? bably 4 DUnknown
Division of Vital Records,	The law recate has bee page 2 short	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of 2 No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Cf			
o	Phys r this ral dir	- T	27. Manner of Death 28a. Date of Injury 28b. Time	e of 28c. Injury at 28d.	Describe how inju		(fy)
ion	nding ith. r: Afte e fune	atior	1 X Natural 5 ☐ Pending (Month, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No			
Divis	al or Atts s after des al Diracto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street ar City or Town, State	nd Number or Rur a)	al Route Number,
7	the Hospital hin 24 hours a the Funaral hpletely filled	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Physicien: To the best of my knowledge, de 2 ☐ Medicel Examiner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occurred a	t the time, date an	d place, and due	to the cause(s)
	Withi To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month,	
	17		30. Name and address of person who completed cause of death (Item 23a) (Type	RES-POD	20	-IEMBER	16,2007
	*		30. Name and address of person who completed cause of death (item 20a) (Type PETER LEARY, THE JOHNS HOPFILMS I	LOSPITAL 600 NORTH WOU	Fe Steat, Br	ALTIMORE, 1	MARYLAND 21205
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type PETER LEAR'Y, THE JOHNS HOPFITNS ITEM 31. Date filed (Month, Day, Year) SEP 1 8 2007	Spertt .			
				F			

07-07055

Johnathan Alton Wi	1- For State Ce Registrar	artment of Health and Mental Hygi ertificate of Death	ene Reg. No. 2007 2987
Physician/ Medical Examiner	OCIVATION ALTON WILSON	. S	nate of Death North Day Year eptember 10, 2007 3. Time of Death 1858 hrs
	4a. Facility Name (if not institution, give street and number) 917 St. Anne Drive	4b. City, Town, or Location of Death Cambrills Street	4c. County of Death Harford
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 230-79-2118 1 XM 2 F 1	Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Virginia
ow any:		y, Town or Location	10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show tifred at once.	10e. Street and Number	10f. Zip Code .	/ 10g. Citizen.of What Country?
er death with , or items 23. r. must be no	917 St. Anne Drive 11. Marital Status 1 X Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed)	U.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)	white, etc. Specify: White
5-0036 ed within 72 hours afth Tygiene. other than "natural" the Medical Examine Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 10 17. Father's Name (First, Middle, Last)	Student	High School
21215- could be filed d Mental Hy, is marked of tic event, the To Be C	Mark Kevin Wilson 19a. Informant's Name/Relationship (Type, Print).		lle Tipler
imore, MD Pages I and 2 she ment of Health and tant: If item 27 is or other traumati	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	917 St. Anne Drive, St. Place of Disposition (Name of cemetery, crematory or other place) Oak Grove Baptist Cem. 9-1	te 20c. Location - City or Town, State 5-07 Bel Air, Maryland
Balt Bermit Depart Import Import	23a. Part I Enter the disease, or complications that caused the deat	22. Name and Address of Facility McComas Funeral Home 1317 Cokesbury Road th. Do not enter the mode of dying, such as cardiac or res	
/Medical xaminer	failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence	of):	Between Onset and Death
ted i msit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence)		
60, are be executed hysician and e burial - transit Medical Ex:	d. UNPENDED #ZAMENDED	71 0/19/07 777	
ox 687 ath certific attending p or use as th	#201,#40,Den'if,go/ IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ires that the designed by the signed by the side by the side by the side by the side by Physical by Ph	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Jivision of Vital Records, P.O. all or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by ed in by the funeral director, page 2 should be detach ritification: To Be Completed by P.	25. Was case referred to medical	26.Place of Death (Check only	24a. Was an autopsy performed? 1 ✓ Yes 2 No 12 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 12 ✓ Yes 2 No
f Vital Physician or this cert ral directo	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nursing Ho	ome 5 Residence 6 Other: Scene
sion of death. ctor: After y the funer.	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month: Day, Year) FOUND: Sep 10, 2007	FOUND: 1700 hrs 1 Yes 2 No Sul	. Describe how injury occurred oject Hanged himself
Division o Spital or Attending hours after death. Increal Director: Aft filled in by the func Certification:	4 Homicide determined (Specify) at home	917	Location (Street and Number or Rural Route Number, City or Town, State) St. Anne Drive, Campbuls, MD
To the Hos within 24 hr To the Fun completely	(Check only one) 2 Medical Examiner: On the best of my knowle and manner stated.	dge, death occurred at the time, date and place, and due and/or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 11, 2007
	with.	1 Penn Street, Baltimore, MD 21201	
State Registrar		the fools	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GROVE If Under 1 Year If Under 24 Hrs.
Months Days Hours 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months 1 2 M 2 □ F 217-24-4/// Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GROVE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Met 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of) 10 years Examiner Sequentially list conditions, in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician certificate be Physician/Medical IF FEMALE: signed by the attendin I be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Year in the past 12 months? Day 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the undedying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of eath Certification: After 5 ☐ Pending investigation Hospital or Attending 1 Natural
2 Accident Injury within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001. S. HANOVER St, BALTIMORE, MD 21225 SEENWASAN MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month Day

Year)

2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. **Physician** Watkins rlenda 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** May and Medical Center Baltimore 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1□M 2**X**F Months Days Hours Min Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARVLAND 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ERNAR ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WATKINS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □ Bartal 2 X Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. 4 Donation 5 ☐ Other (Specify) TIMORE, MARVLAND 21. Signature of Funeral Service Licensee LRO 23a Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line.

In rediate Cause (Final rediate Cause (Final rediate Condition resulting in death)

a. Due to (or as a consequence of the condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trail Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient ဂ္ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HMelia Kandall

31. Date filed (Month, Day, Year) SEP 1 8 2 A44176435R17640

22 S. Greene St. Baltimore, ND 21201

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 17 29875

		-	State Registrar		Cei	tificate of l	Death	R	و . No.	001	27010
		#1	Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	th Day	Year	3. Time of Death
Si.	Physicia /Medic		Dorothy	Kemball Walker				Septemb	er 1	.2, 2007	12:50 AM
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. C	County of Death	
* 4		$\hat{\sigma}_{\widehat{T}_{\ell}}$	Friends Nursi	ng Home			Spring		1	Montgome	
	Funeral		5 356-30-1485	5. Sex 7. Age (In yrs. Is 1 ☐ M 2 ☒ F 102		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthr	place (State or Foreign
ı.	Director		230-46-0399	103	Yrs.			September	24,1	.903 Wash	ington, D.C.
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation				1	Od. Inside City Limits
	/anyl	ō	Maryland Mont	comery	Sandy	Spring					1 ☐ Yes 2 🔣 No
	289-	Director	10e. Street and Number	50mery	Danay	10f. Zip Code		1	0g. Citiza	en of What Cou	ntry?
	with 3e or	Ö	17434 Quaker L	nne			20860		Unit	nited States	
	death ms 2:	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	5. 13.1	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14	4. Race - Americ	
Maryland 21215-0036	s i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "netural; or Items 23s or 28e-f show other traumatic event, Ite Medical Ever first marked multiped at	þ	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? d 1 □ Yes 2 ဩ No If Yes, Give Year or Dates:	- 1	1 ☐ Yes 2 ☐ No	Specify:	nicari, etc.)	5	Black, White, Specify: Wh	nite
2-0	72 hc netui	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced	dent's Usual Occup	ation during most of working	ng		d of Business/In	•
2	ithin han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Teac		d)		Syst	lic Scho	001
2	led w lygier her ti	S	17. Father's Name (First, Middle, L	5+	reac	ner	18. Mother's Name	(First Middle			
and	ntal hed on the fed of	Be								, , , , , , , , , , , , , , , , , , , ,	
Ž	houte d Me nark natio	ပ	William M. Kem 19a. Informant's Name/Relationsh		19h Mailir	nn Address (Street	Jessie : and Number or Rura			Town State Zit	Code)
<u>S</u>	d2s than than trau		Jeanne W. Hough						_		land 20906
ď,	1 an Heal tem 2		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of				ation - City or To	
altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 It any injury or other tra once.		1 ☐ Burial 2 MCremation 4 ☐ Donation 5 ☐ Other (Sp	acity) Mont	gomery(Inc. 15,	2007		esda, Ma	
Bal	permit Depar Impor any in		21. Signature of Funeral Service &) o(5 Rc 75	Name and Addre Sbert A. Pur 57 Wisconsi	ss of Facility hiphrey Funer In Avenue, B	al Home/lethesda,	Bethe Maryl	sda-Chevy and 20814	Chase, Inc. -3501
П			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused the death nly one cause on each line.	. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	Arterioscl	erotio	Heart D	isease				6 Years
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
B	LAGITITIET		Sequentially list conditions,	b							
_	sit s	ine	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or as a consequ	ence or):						
77	ertificate be executed ling physician and e as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):					-	
68760,	be e. ician buria										
387	icate phys s the	Medicai		d							
ox e	certif nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23	3d. Date of deliv	өгү
œ	ires that the death cossigned by the attend signed by the attend I be detached for uso	by Physician/	in the past 12 months? 1 Yes 2 No	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		Ectopic pregnancy Other (specify)	/			Month	Day Year
P.0.	at the d by ti	Phy	9 Unknown		M* * - AI		a la Daniel	22a Didta	baasa us	a enetribute to t	he cause of death?
Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d by	Part II. Other significant condition	s contributing to death but not resu	illing in the u	nderlying cause giv	en m Part I.	1			babiy 4 Unknown
00	w requir been si should	Completed						24a. Was a	an	24b. Were auto	opsy findings available
Re	he la e has age 2	d L						autops	med? 2 No	prior to co death? 1 \(\sum Yes	mpletion of cause of
ā	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Death			1 105	2 140
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Ö	ath. r: Afr	atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investig	ition	,,		Yes 2 □ No				
Division of	or Atter de after de l'Directo	Certification;	3 Suicide 6 Could n 4 Homicide determi			eet, factory, office		28f. Location (S City or Tow	treet and n, State)	l Number or Run	al Route Number,
	To the Hospital or Attanding Physician: The lawinin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of my know xeminer: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the tir vestigation, in my o	me, date and place, opinion, death occurr	and due to the cred at the time, c	ause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date	e signed (Month,	Day, Year)
)	->-0		> WM	W) M		D23	3124		Sep	tember	13, 2007
	:		30. Name and address of person v	no completed cause of death (Item	23а) (Туре,	Print)					
_	6		Dennis M. Hann	on, M.D. 2901 O	lney-S	andy Spr	ing Road,	Olney,	Mary	yland 20)832
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1	32. Pegistrar's Signal	B. A	parle					

Patient Known as Vinginia Weiss Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, C.

				State of Ma	arvland	1 / Dena	artment of	f Health	and M			
	-			-f Per INF	G873	11/28	(07 JH tillcate o	f Deat	h		leg. No. 2 11 11	7 29876
Physicia /Medic	an	1. Decedent's Nam VIRGIN		astj			WE	ISS		Seet	Day Yea	
Examin	0	4a. Facility Name (• 1	ive street and number)	within	nd/e	4b. City, Town	n, or Location	_	ity	4c. County of De	N/A
Funeral Director		5. Social Security N 446-24-	5439	Sex 7. Ag 1 ☐ M 2 🔀 F	je (In yrs. Ia 88	ast birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Date of Birtl (Month, Day 08/08/	, Year)	lirthplace (State or Foreign Country)
aryland show	'n	Usual Residence o 10a. State Florida	10b. County Palm	Beach		, Town or Lo		Palm 1	Roach			10d. Inside City Limits
h the M or 28a-f or notifie	Funeral Director	MD- 10e. Street and Nu		South Ocea		7dl	10f. Zip Cod		Lacii		10g. Citizen of What	
eath wit is 23a c nust b	eral		LD COURT	ROAD, #500	Ever in U.S	BD1	Was Decedent			30-5409 ecify Yes or No-		SA merican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status 1 □ Never Mari 3 □ Widowed	ried 2☐ Married	Armed Forces?	No		If Yes, specify C 1 ☐ Yes 2 2 1			ecify Yes or No- Rican, etc.)		hite, etc. WHITE
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permi Depa Impo any ir		MU	Choul	Drugo	U				STOWN	ROAD -	PIKESVILL	E, MD 21208
Physician		23a. Part1. Enter shock, or he immediate Cause disease or condition	art failure. List or (Final	mplications that cause ly one cause of each t	ne.		ter the mode of				rest,	Approximate Interval Between Onset and Death
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faw rec las beel 2 shou	plete	CVA								24a. Was	osy prior	autopsy findings available to completion of cause of
	Com	25. Was case refe	perred to medical	Anemia				26 DI	lace of Deat	1 Yes	rmed? death	
ysicla is certi directo	o Be	examiner?	DNO	Hospital: 1 ☐ Inpat	ient 2 💽	R/Outpatie	nt 3 DOA	Othor:			dence 6 Other (S	Specify)
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210		30. Name and ad		no completed cause of	death (Item	23a) (Type	Print)	٠٠٠	285	pital	~ R-11	ina ac
TH Sta	ate	31. Date filed (Mo		32. Regis	trar's Signa	iture	111	NG!	ros	pHal	Of Dalt	TIME
Regist	rar		SEP 1	3 2007 July	que	St A	Breeze					

			State of Maryland / Department of Health and M State of Maryland / Department of Health and M State of Maryland / Department of Health and M Registrar	lental Hyg	giene Reg. No. 200	7 29877
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
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7	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WWW. Walling A. Centry			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. North Days Hours Min.	8. Date of Birth (Month, Day	r, Year)	irthplace (State or Foreign Country)
	Director		213-27-7120 1(X) M 2 F 21 Yrs. 1	Feb. 9,	1986 Wa	shington, DC
	how at		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar Ba-f sl	Director	MD Calvert County Owings		10 000	1 □Yes 2XNo
	a or 2	Dire	10e. Street and Number 7260 Briscoes Turn Road 20736		10g. Citizen of What $U_\bullet S_\bullet A$	
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto	ecify Yes or No-		nerican Indian,
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	nd 2 sith 8 27 L		Martha E. Anderson (Mother) 7260 Briscoes Turn Road			
ore			20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept.		20c. Location - City	
altimore,	permit. Page Department of Importent: If eny Injury or once.		4 □ Donation 5 □ Other (Specify) Lee Crematory 20 21. Signature of Fundamental License 22. Name and Address of Facility Lee		Clinton, 1 Home Ca	
ä	Depired Impo		Michael W. Les 8125 Southern Mary			
1			23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac cannot shock, or heart failure. List only one cause on each line.	or respiratory an	rest,	Approximate Interval Between Onset and Death
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Box	leath certifica attending ph I for use as th	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of Month	delivery Day Year
<u>.</u>	at the de by the a tached f	Physician/Med	1 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown			
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Division	Attend death ctor: /	ficati		28f. Location (S	Street and Number or	Rural Route Number,
2	al or / s after al Dire ed in b	Certification:	4 ☐ Homicide building, etc. (Specify)	walton	Pord & Cali	whom School Rd
	Hospit 4 hour Funera ely fille		29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the or	cause(s) and manner date and place, and	as stated with mound fue to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification the Funeral Director, the funeral director, completely filled in by the funeral director,	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
	⊢≯⊢ŏ		Allega up Pollegan: 18231		8/30/	07
	F		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-1 '	•
	2)		Amber Rollstin, M.D. 22 S. Green Street, Baltimore, 31. Date filed (Month, Day, Year) SEP 5 2007	, Maryla	and 21201	
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State of Maryland	Department of Health and N	Mental Hygien	U	U	

29878 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 8:30P м September 5 2007 Paul Revere Avey, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington County 920 Marion Street Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Y Feb 2 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1(XM 2□ F 235-28-3364 86 Yrs. Director West Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show rthen "natural", or itame 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Maryland Washington Hagerstown Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or U.S.A. 21740 920 Marion Street death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 *natural', or þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Co. 8 Lineman of Health and Mental Hygie If Item 27 Ie marked other I or other traumatic event, II other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked eny injury or other traumatic events. Edna Lee Moler Avey ဥ Paul Revere Avey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 Harvard Road Hagerstown Maryland 21742 Helen Youngblood - sister 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Centerlary, crematory or other place)
Cedar Lawn Mem Park | Sept 8 07 | Hagerstown Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Anterio Schristiz Cardio Vanalen **Physician** /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Chian? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Chiana ortunda 24a. Was an Dinear autopsy performed? certificate 1 ☐ Yes 2 ☐ No Aline 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 140 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Matural death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Medical 29a. Certifier 1 - certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D (8019 contino 5507 6,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-6 MILL JT MAGERSTOWN MD 2174: DATTAMO VASANT 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and Martificate of Death	ental Hygiei Reg.	71111 / 748 / 4
	21		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	Physicia Medic		Eddie Borjesson			MA 22:11 FOOS PR
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	7	4c. County of Death
			Holy Cross Rehabilitation 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Burtonsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery
	uneral rector		181−03−0689 1 XM 2□ F 95 Yrs.	Months Days Hours Min.	(Month, Day, Ye 12-25-191	
_	i ector		Usual Residence of Decedent		12-23-191	1 New York
rylanc	how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
e Ma	28e-f show	cto	Maryland Prince George's College	Park		1 Mayes 2 No
đ H	or 21	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
ath v	s 23a	Funeral Director	4800 Guilford Road	20740		U.S.A.
ter de	Itam	n	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	city Yes of No- Rican, etc.)	Black, White, etc.
If I I I I I I I I I I I I I I I I I I	"natural", or Itams 23a Idical Examiner must I	by F	If Yes, Give 3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
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ed wi	t the		5+ Engi			wn Company
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should I	Is marked other than aumatic avent, the M	ဥ	Berndt Borjesson 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Sigrid I		hy or Tourn State Zin Code)
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es 1 and of Health	if item 27 is marked other than "natural", or itams 23a or 28e-f shov or other traumatic avent, the Medical Examinar must be notified at		20a. Method of Disposition 20b. Place of Disp	O Guilford Road, Co		. Location - City or Town, State
Pages			1 Li Buriai 2 XI Cremation 3 Li Removal from State	matory or other place) an Crematory 9/1/2	2007 4	lexandria, Virginia
permit. F	Important: If any injury or once.			2. Name and Address of Facility	.007 A.	4739 Baltimore Ave.
3 8 8	any ir		1/dmi Thomas 1701373	Gasch's Funeral Hom	ne, P.A.	Hyattsville, MD 20781
			23a Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
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he la	e has	Completed			autopsy performed	prior to completion of cause of death?
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ysici	direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	0.0		6 Other (Specify)
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lendi eath.	or: A	catl	2 Accident investigation	M 1 Yes 2 No		
or At	Jirect in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	8f. Location (Street City or Town, St	and Number or Rural Route Number, late)
pitel	filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the cause	a(s) and manner as stated
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To th	To th	Me	29b. Signatore and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Would Sego	00053337	8	f005/129/1
- 6	(0)		30. Name and address of person who completed chose of death (Item 23a) (Type	, Print)		
7				enue Suite 203	paltino	re, My 21500
	Sta Registr		31. Date filed (Month, Day, Yèar) SEP 0 4 2007 SEP 0 5. Special D. Special D.	•		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #20a-c Per FH 687 2670 JH / Department of Health and Mental Hygiene Registra 9-4-07 Amend #8. Per FHPC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 840 AM Day Year **Physician** 4a. Facility Name (If not institution, give street and number) August 30 2007 /Medical 4c. County of Death Town, or Location of Death Examiner hever) Rince Georges rince George's Hospital Center If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth4_11_1942 9. Birthplace (State or Foreign (Month, Day, Year) ial Security Number Age (In yrs. last birthday **Funeral** Months Days -2880 1 □ M 2 🔀 Yrs 65 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after death with the Marylan lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show tranmatic event, the Medical Examiner must be notified at tranmatic event, the Medical Examiner. MD andover 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: vante, etc. A menai 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Dietician ひ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be sephine ၉ no K 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. #804 20018 3298 Lincoln DR. WDC 20a. Method of Disposition 20b. Place of Disposition (Name of 9/20/2007 Riverdale MD 2 XX remation 3 ☐Removal from State 5 Other (Specify) 4□Donation ASSOC. FUTERUL 21. Signature of Juneral Service Licenses onnette 23a. Pars Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Due To Methicillin Resistant Staphylococcus Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Pulmonary Sarcoidosis
Due to (or as a consequence of): anding physician and use as the burial-tran P.O. Box 68760, attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Drabetes mellitua Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00012015 8-30-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

State Registrar 31. Date filed (Month, Day, Year) SEP 0 4 2007 32. Registrar's Signature

20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month JAMIES p. RRUNI :24 PM AUG 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOWARD HOWARD COUNTY SENGRAL (HOSPITAL Counsia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept 13 (1918) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F 88 Director 005-12-2837 Maine the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 No MD Ellicott City Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21043 by Funeral 4743 Ilkley Moor USA 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 □ No WWII If Yes, Give Year or Dates: 1940–45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2ĔNo 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railway Express Co. Clerk is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gaetana Villanucci Vincenzo Bruni 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80906 Department of Health a Important: If item 27 is any injury or other trainonce. 4235 Stone Manor Heights Colorado Springs, CO Jerome Bruni/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01442 4112 Old Columbia Pk. Ellicott City, MD Ven 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIL SHOCK 2 HOURS /Medical Due to (or as a consequence of): Examiner PAN COUTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and BOWEL ISCHEMIA nding physician and use as the burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ed by the a detached f 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CLOSTRIDIUM MIGGICILE WRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1∐Yes 2∐XMSo 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 Pending investigation ieral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division or Vital Records, P.O.

DIAND WAY IZW MO 10724 LITTLE PATUXENT PKWY 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

State Registrar (Check only one)

29b. Signature and title of certifier

29c. License number

036974

COLUMBIA MD

29d. Date signed (Month, Day, Year)

31

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29882 Reg. NoZ U 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Allan Lee Blackburn August 9:30 AM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** East 3 W. Old Philadelphia Hoad Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs **Funeral** 1 X M 2 □ F Hours Director 225-68-1861 July 16, 1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1583 West Old Philadelphia Road 21901 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces Vietnam
If Ves. Give
Year or Dates: War Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 ☐ Widowed 4 🎇 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Trucking 7 is marked other traumatic event, the with and Mental Hy
7 is mark 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willard G. Blackburn Sylvia Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. Duke G. Blackburn/Son 404 Greenbriar Avenue, Keene, TX 76059 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery 6, 2007 Port Deposit, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Sign ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pheumonia Secondary to Chronic Bronchiectasis Physician Unknown /Medical Examiner hronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Recurrent Aspiration Preumonia, Status 1 Yes 2 No 3 Probably 4 Unknown Be Completed Tumor Surgery with Residual 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ranial Nerve Pulsies and D 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

VA maryland Health Care System, Perry Point, MD 21902

		4	For State Registrar	State of Maryl		artment of H <i>rtificate of L</i>				1 20003			
		4	Decedent's Name (First, Middle, Last) 2. Date of Death Month Month O (200 Paynor) Year 1.										
Ι.	Physicia	_	Marco Bellosi, S					Month 08/23	B/2007 Yea	11:59 a ^M			
2.	/Medic Examin	_ 1	4a. Facility Name (If not institution, g.			4b. City, Town, or	Location of Death		4c. County of Death				
	Examin	eı	Calvert Memorial			Prince	Frederic	le.	Calver	t			
	Funeral		5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. E	Birthplace (State or Foreign Country)			
	Director		579-56-3750	1 X M 2□ F 63	Yrs.	Months Days	Hours Min.	11/19/19		ashington, DC			
	PI	ļ	Usual Residence of Decedent	140	Oit. T					10d, Inside City Limits			
	trylar show	_	10a. State 10b. County	l l	. City, Town or L					1 ☐ Yes 2 No			
	e Ma Ba-f s	Director	MD Calver	rt	Dunkir				C110				
	or 2	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?			
	ath w	<u>ra</u>	11520 Southern M				754	anife. Van au Nie	U.S.A.	merican Indian,			
	er de	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, W				
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛮 No	Specify:		Specify Wh	ite			
8	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted b	15. Decedent's		16a. Dece	edent's Usual Occup	ation	161	o. Kind of Busine				
21215-0036	in 72 i "na ledio	Completed	(Specify only highest g	rade completed)	(Give	e kind of work done o DO NOT use retired	furing most of work)	ing					
12	with iene. thar	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Self	Employed			Steel S	uply			
9	filed Hyg Sther ent, 1	Be C	17. Father's Name (First, Middle, La.	st)			18. Mother's Name	e (First, Middle, Mai	den Surname)				
Maryland	ld be enta ked ked	To B	Emrick Amerigo	Bellosi			Ernest	ine		N/A			
ary	nd M mar mar		19a. Informant's Name/Relationship		19b. Mail	ing Address (Street	and Number or Rui	al Route Number, C	ity or Town, State	e, Zip Code)			
Š	nd 2 ulth a 27 is r trau		Linda Bellosi	'Wife	P.C	. Box 135	9 Upper M	Marlboro,	MD 2077	3			
ē,	s 1 a f Hea ltern othe		20a. Method of Disposition	2	0b. Place of Disp	osition (Name of ematory or other place	Aug.	Date 20	c. Location - City	or Town, State			
9	Page ent o nt; If		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Contro	☐Hemovai from State		Mem. Gard	, ,		unkirk.	Maryland			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	li	21. Signature of Funeral Service Lic							lvert, P.A.			
ä	Dep Imp any ono		Cary J. Goff			125 South							
			23a Part 1. Enter the disease, or co	mplications that caused the						Approximate Interval Between			
	Physician		shock, or heart failure. List on Immediate Cause (Final	Post-of-s	truchi	Ma 100-	50 11 1111	uia >		Onset and Death			
	/Medical		disease or condition resulting in death)	Due to (or as a co		pr	ecourse						
8	Examiner			Supul	roll	- lu	nox co	nices					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	_		ilur					
	uted	Examiner	Cause (Disease or injury that initiated events	, acute	reno	I fai	lune			V			
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	as as	led		V			<u> </u>						
Box	death certifii e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐		□Ectopic pregnancy	/		23d. Date of				
m	0 0 0	ici Si	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time 9□Unknown		Other (specify)			Month	Day Year			
P. O.	at the by th tache	h	9 Unknown										
	law requires that the death cer as been signed by the attendin 2 should be detached for use	by F	Part II. Other significant conditions	s contributing to death but no	ot resulting in the	underlying cause giv	en in Part I.			e to the cause of death?			
ğ	w require been sig should b							1 L Yes	2 No 3 D	Probably 4 ☐ Unknown			
Records,	law nas be	Completed						24a. Was an autopsy	prior	e autopsy findings available to completion of cause of			
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İta	ian: ertifica	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th Check onl one					
>	ding Physician: The lav n. After this certificate has funeral director, page 2	To E	1 Yes No	Hospital: Inpatient	2 ER/Outpatio	ent 3 DOA Oth	er: 4 🗌 Nursing H	ome 5 Residen	ce 6 □Other (S	Specify)			
0	ng PI ter th		27. Manner of Death 1	28a. Date of Injury (Month, Day Ye	28b. Time lar) Injury		yat k?	28d. Describe how	injury occurred				
Division or Vital	Attending r death. ector: After by the funer	Certification:	2 ☐ Accident investigat			M 1 🗆	Yes 2 □ No						
Š	r Atte er de irecte	tilio	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, s specify)	street, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,			
	Ital or rs aft ral Direction	Cer						1					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Ex	Physician: To the best of maniner: On the basis of exa	amination and/or	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	, and due to the cau rred at the time, dat	se(s) and manne e and place, and	er as stated. due to the cause(s)			
	the hin 24 the hin 24 the hindet	ledi	one)	and manner stated		29c. Licens	o number	20.6	L Date signed (M	Anoth Day Year)			
	Vitl Con	Ž	29b. Signature and title of certifier	00 1	. 0		10604		2/97	Nonth, Day, Year)			
•			Pull 10) rw	NU	1		, 0	0/2	11 200 1			
. `	F		30. Name and address of person w	no completed cause of death	(Item 23a) (Type	e, Print)	B 10 00		~	1010 2 063 C			
Ŋ	_			NSH (00 +	Signatura	He KK	AD, PKI	VLETRE	PEILLER	, MD 20678			
	Sta Regista	ate	31. Date filed (Month, Day, SEP)	4 2007	Mare .	dias to	r						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physician Keith Alan BROWN Sept. 3, 12:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XM 2□ F Months Days Hours 46 219-84-1092 Director 9,1961 Maryland Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7610 Overlook Drive 21713 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) drywall hanger construction 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Robert Brown Connie Lowman P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Oestereich - mother 7610 Overlook Dr., Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hagerstown Crematory 9/5/07 Hagerstown, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME COU 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caused on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lamplications **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any, reading to inmediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1⊟ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
Yes 2□ No Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Herelit 21 after death.

I Director: / **Accident** 10,01 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 4 a Known 471 Kyewy 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

The law requires that the death certificate be executed O. Box 68760. σ. Records, Vital Division or

Baltimore, Maryland 21215-0036

54-2

State Registrar

31. Date filed (Month, Day, Year) SEP 0 6 2007

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251 €. istrar's Signature

and manner stated

29c. License number

DUOS 696-5

29d. Date signed (Month, Day, Year)

2007

		1	For State of Ma		artment of He	ealth and Mental Hy <i>Death</i>	ygiene Reg. NZ 007	29885
Phy	/sicia		Decedent's Name (First, Middle, Last)			2. Date of D Month	eath Day Yea	3. Time of Death
/N	ledica	al -	STERLING LEE BOWERS 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Depter		
Ex	amine	r	FAHRNEY-KEEDY HOME			OONSBORO		HINGTON
Fund	eral			e (In yrs. last birthday		If Under 24 Hrs. 8. Date of B (Month, D		Birthplace (State or Foreign Country)
Direc	ctor	-	226-38-7925	83 Yrs.		APRIL	20,1924	MARYLAND
aryland	14		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
e Mar	Dailli	çi	MARYLAND WASHINGTON		BOONSBO)RO		1 ☐ Yes 2 🛣 No
death with the Maryland ms 23e or 28e-f show	De la	Director	10e. Street and Number		10f. Zip Code	01.71.0	10g. Citizen of What	•
Jeath ns 23	ISM	Funerai	8507 MAPLEVILLE ROAD 11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	21713 spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.)	U.S 14. Race - A	merican Indian,
6 after or Iter			Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ I If Yes, Give	No 1943-	If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Rican, etc.) Specify:	Black, W Specify:	
003 hours	al Exa	od by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1963				WHITE
7. rin 72	Asolica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired)	uring most of working	16b. Kind of Busine	ss/industry
212 d with giene.	1	E C	Elementary/Secondary (0-12) College (1-4or 5		CAREER SOI	DIER	U.S. ARI	MY
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e.f show	•vent	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle CADDIE EDNIA EUR		
ryla hould d Mer marke	matic	၉	CHARLES EDWARD BOWERS 19a. Informant's Name/Relationship (Type, Print)	19b Mail	ing Address (Street a	CARRIE EDNA FU		a. Zip Code)
Ma nd 2 s alth an 27 is	r treu		FUNERAL HOME RECORDS		100	NAL PIKE, BOON		
Baltimore, Permit. Pages 1 ar Department of Hee	r othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disp		Date	20c. Location - City	
time. Page ment	orni		* 4 □ Ponation 5 □ Other (Specify)			TERY 9/06/2007		
Bali permit Depar Impor	any in		21. Signature of Fyneral Licensee	İΞΛ	2. Name and Address ST FUNERA	TIOME 7000 OI	ld National oro, Maryla	
			Kelly A. Z 23a. Part/ Elter thi disease, or complications that caused shook, or hear failure. List only one cause on each li		nter the mode of dying			Approximate Interval Between
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/Medi Exami	ical		resulting in death)	consequence of):	(0.0	1	~ 1.6
LXaiiii		5	Sequentially list conditions, b.	a consequence of	-ructile	I'll money	discare	7.7
pein	ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	avat dive	vet this's			784
8760, rate be execu	the burial-transit	Ĭ.	resulting in death) Last Due to (or as	a cons uence of):				
SX 68760, certificate be executed riding physician and	the b	dicai	d					
ds, P.O. Box 6	use as	Physician/Me	IF FEMALE: 23c. If yes, outcome				23d. Date of	delivery
B. Boath	od for	sicial	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O. that the ed by th	etach	Phy.	9 ☐ Unknown Part II. Other significant conditions contributing to death b	out not reculting in the	undarhing agusa giva	n in Part I 23a Din	I tahacca use contribut	e to the cause of death?
ords,	o eq p	۵۵	-art ii. Other significant conditions contributing to death b	out not resulting in the	underlying cause give			Probably 4 🗖 Qnknown
D & D	should	Completed				24a. Wa		autopsy findings available
Wital Rec	oage 2	mo.				aut per 1 ☐ Yes	formed? death	to completion of cause of 1? ∕es 2□ No
cien:	octor, p	Bec	25. Was case referred to medical examiner?			26. Place of Death (Check only		
of Mia Physicien: this certific	al cire	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie			4 dising home 5 ne	sidence 6 Other (See how injury occurred	Specify)
on on iding	funer.	tion	27. Manner of Death 1	iy Year) Injury	Work	es 2 □No	s now injury occurred	
Division I or Attending after death. Director: Afte	by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inj	jury - At home, farm, s tc. (Specify)	treet, factory, office		(Street and Number or own, State)	Rural Route Number,
and or or or or or or or or or or or or or	ed in							
Division of To the Hospital or Attending Physical Attending Physical Control of the Funeral Director: After this	completely filled in by the funeral cirector, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medicel Exeminer: On the basis of and manner st	of examination and/or is				
To the vithin ?	somple	¥e	29b. Signature and title of certifier		29c. License	number	29d. Date signed (M	
			Core of	2	DJ.	2323	09-04-	2007
- 6 il 2			30. Name and address of person who completed cause of c					
WH-3	Stat	0	Khalid M. Waseem. M.D. 1	126 Opal C	ourt, Hage	erstown,Marylan	nd 21742	
Re	Stat gistra	ir	31. Date filed (Months Bay Year) 2007 32. egistr	rar's Signature				

Certificate of Death

Name and address of person who completed cause of death (Item 23a) (Type, Print)

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 22 No 2 No 1 Yes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) ORE NO 4203 QUEUSbury Rd Hyattsville Mo 20281

23d. Date of delivery

Month

3. Time of Death

7:35 p.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Sierra Leone

Day

2007

1961

4c. County of Death

Prince George's

14. Bace - American Indian Black, White, etc.

MD 20910

Dav

Approximate Interval Between Onset and Death

6 month

envs

Specify: Black

State Registrar

31. Date filed (Monti Sta)

Certificate of Death

2. Date of Death

26,

3. Time of Death

9. Birthplace (State or Foreign Country) New York

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

8:00 aM

Year

2007

Montgomery

United States

Specify:

Race - American Indian, Black, White, etc.

White

Brentwood, Maryland

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

8/27/2007

4c. County of Death

1. Decedent's Name (First, Middle, Last)

Physician

State Registrar

DHMH 17 Rev 1/2001

D50637

12516 Noble Court, Potomac, Maryland 20854

alu

32. Redistrar's Signature

death (Item 23a) (Type, Print)

30. Name and address of person who completed cause

2007

Shakuntala Malik, M.D

31. Date filed (Month Ser, Year)

			for State Registrar	State of Ma		partment of F ertificate of		лептаг ну	Reg. No 200	7 29888	}				
	Physici	an	1. Decedent's Name (First, Middle, Las	,				2. Date of De Month		3. Time of Death					
	-/Medi		VIRGINIA		BAI	RTLETT		08	31 200	07 1635 ^M					
)	Examir	ner	4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·			r Location of Death		Death						
			WMHS-BRADDO 5. Social Security Number 6. Se		e (In yrs. last birthd	CUMBER		8. Date of Bir	ALLEGA	XIN Y 9. Birthplace <i>(St</i> ate or Foreign					
	Funeral Director		214-14-7617	□ M 2 7 F	86 Yrs	Months Days	Hours Min.	(Month, Da	ay, Year) 27, 1921	Country) Maryland					
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits					
	Marylan I-f show fied at	ţ	Maryland Al	legany			Pekin			1 ☐ Yes 2 XNo					
	h the or 28s	Director	10e. Street and Number	3		10f. Zip Code			10g. Citizen of Wh	nat Country?	_				
	th will	<u>a</u>	17735 Lower Ge	orges Creek R	load S.W.		21546			U.S.A.					
	ems er mı	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 1	 Was Decedent of H If Yes, specify Cub 	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	14. Race -	- American Indian, White, etc.					
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 16 N If Yes, Give Year or Dates:	Vo	1 □ Yes 2 🗖 No	Specify:		Specify:	White					
5-0	72 ho natur fical I	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	cedent's Usual Occup	nation	kina	16b. Kind of Busi		ī				
21	ithin he.	nple	Elementary/Secondary (0-12)	(0-12) College (1-4or 5+)		e. DO NOT use retire	d)	ung							
	Hygier Hygier ther th		5	0			Cook	o /First Middle	Restaurant ddle, Maiden Surname)						
Maryland	ould be f Mental H arked ot atic ever	Be C	1						es Jane Leath						
Z	2 should and Men is marke aumatic	ို	19a. Informant's Name/Relationship (7			ailing Address (Street	and Number or Ru				_				
M	and 2 ; ealth ar n 27 is ier trau		Mary Muir -							Maryland, 21539					
Je,	ss 1 and 2 of Health Item 27 I		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other place		Date September	20c. Location - Ci		_				
Baltimore,	Pa In the		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	1	nberland Crem	atory	04, 2007		Cumberland, Maryland					
Ball	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		21. Signature of Funeral Service Licen	see	_	22. Name and Addre									
10			23a. Part1 Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in Show, or heart failure. List only one cause on each line.												
	Physician		Immediate Cause (Final disease or condition			Interval Between Onset and Death									
4	/Medical		resulting in death)	Due to (or as				_							
Н	Examiner	Ļ	Sequentially list conditions,	b											
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or Injury	Due to (or as a	a consequence of):										
,	execunate and al-train	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				_						
68760,	tificate be executed g physician and as the burial-transit	edical		.d											
	rtificat ng phy as th	ledi	15 EF 111 F												
Вох	attending for use a	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	v			23d. Date of delivery							
Ö	The law requires that the death cert the has been signed by the attendinage 2 should be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)						Monti	h Day Year					
σ,	s that ned by deta		Part II. Other significant conditions co				en in Part I.	23e. Did 1	tobacco use contrib	oute to the cause of death?					
Records,	w requires been sign should be	Completed by	LORONARY	ARTER	CY DR	SEASE		10	Yes 2□No 3	□ Probably 4 □Unknown					
၁၁	has bei	plet	DIABETES	7				24a. Was auto	an 24b. We	ere autopsy findings available or to completion of cause of					
<u> </u>	(0 -	Com						perfo	ormed? dea	ath? Yes 2 No					
Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hanaitali .			26. Place of Deat	th (Check only o	one)						
or	S	P	1 Yes 2 No 27. Mann Death	Hospital: 1 Inpatie			4 L Nursing H		dence 6 □Other						
	ffer ne	tion:	1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 28b. Tim <i>y Year)</i> Injui	y Wor	ryat rk? Yes 2 □ No	28d. Describe	how injury occurred	1					
Division	Atten deatl ector:	ficat	3 Suicide 6 Could not be	28e. Place of inju	ury - At home, farm,	street, factory, office	,,,,	28f. Location (Street and Number	or Rural Route Number,					
Ö	tal or is after al Direct	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)			City or To	wn, State)						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical			examination and/o	eath occurred at the ti r investigation, in my o				ner as stated. nd due to the cause(s)					
	To th Withir To th comp	Me	29b. Signature and title of certifier	2 -19	222	29c. Licens	e number		29d. Date signed (Month, Day, Year)					
			Thm	La	me	_ 1000	54004		1/2/	7					
		2	30. Name and address of person who o	completed cause of de	eath (Item 23a) (Typ	pe, Print)		0 01	1	4					
		7	Shir KHANNA	MD. 100	XI E , NF	HIONAL	1. YWH	AVAle	_ MO 2	1502	_				
	Sta Registr		SEP - 6 2	007 32. Hegistra	ar's Signature	Acasti,	•								

07-06807 Samuel Eduardo Bonilla

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 29889

			1- For State Certificate of Death Reg. No.												
	Physicia		egistrar I. Decedent's Name (First, Middle,Last)								2. Date of Death Month September 2, 2007 3. Time of Death 0757 hrs				
€	Examir		Samuel Eduardo Bonilla								Septembe	0/5/ 11/5			
7			Samuel Eduardo Bonilla 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Fort Washington Hospital Fort Washington									4c. County			
			Fort Washington Hos				Fort Was	hingt	Dn			Prince (
		4	5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1	Year	If Under	24Hrs.	8. Date of Bir	th (MM/DD/YYY	Y) 9. Birth	nplace (State or DC	
	Funeral	- [5. Social Security Number		,,,,,go (),,,,,,,,,				Hours	Min.	,		roreigi	untryWashington	
	Director	- 1	579-39-6394	1 <u>X</u> M 2 F	2	Yrs.					06/0	1/2005		Wasiiiiigcom	
			Usual Residence of Decedent		1.0 OV T-	wn or Locatio								10d. Inside City Limits	
>0	any		10a. State 10b. County			WI OF LOCATIO	PFT							1 X Yes 2 No	
2	nd thow	-	MD Pri	andove	r										
3	Maryland 28a-f show d at once.	당	10e. Street and Number		-	10f. Zip Code					10g. Citizen of What Country?				
0	or 2	Director		rest Rd.	Ant 101		207	785			FEY	USA			
	death with the Maryland or items 23a or 28a-f sho must be notified at once.		6500 W F'C	12. Was De	cedent Ever in U.S.	13. Was	Decedent o	f Hispa	nic Origin	n? (Spe	cify Yes or No	o- 14. Rac		can Indian, Black,	
	ath w	Funeral		Married Anned F	orces?	If Yes, specify Cuban, Mexican, Puerto					o Rican, etc.) White, etc.			spanic	
	or de	교	3 Widowed 4 D	1 Yes		1 🗴	Yes 2	No :	specify: T	11 S	alvado:	rian Specify	:	spanie	
	5-0036 led within 72 hours after death with the Maryland tygiene. When than "matural", or items 23a or 28a-f sho ther than "matural", or items to notelited at once	ā	15. Decedent's Education (Sp	or Dates:		6a Decedent	's Usual Occ	upation	(Give ki	nd of wo	rk done	16b. Kind of E	Business/I	ndustry	
	hour matu Exar	Completed	Elementary/Secondary (0-12		(1-4 or 5+)	during most of working life. DO NOT use retire Never worked					ed)				
	n 72 n an isan	bie	0	, Jones	, , , ,										
	5-003 filed withir Hygiene. d other th		17. Father's Name (First, Midd	lo Last)		1.7	CACT N	18	Mother's	Name (First, Middle,	Maiden Surnam	ne)		
	Hygh Hygh									1.411	iemae	Marie I	larai	n	
	21215-0036 uld be filed within 72 h Mental Hygiene marked other than "r c event, the Medical E	Be	Julio Bonill 19a. Informant's Name/Relatio	a Brint		19h Mailing	Address (Street a	and Numb	per or Ru	ural Route Nu	imber, City or To	own, State	e, Zip Code)	
	ID 21215 should be file and Mental H is marked of matic event, ti	2				l .						andover		1	
	1 日本 日本 日本 日本 日本 日本 日本 日本 日本 日本 日本 日本 日本		Julio Bonill	<u>a/father</u>	20h Pla	ace of Dispos				Арц	Date	20c. Location	n - City or	Town, State	
	imore, MD 2. Pages I and 2 should ment of Health and M tant: If item 27 is m: or other traumatic en	ı	20a. Method of Disposition 1 X Burial 2 Cremat	ion 3 Removal	from State cre	ematory or oth	ner place)								
	nol		4 Donation 5 Other		For	t Line	coln C	eme	tery	9/1	0/07	Brentw	ood J	MD	
	Baltimore, permit. Pages 1 an Department of Hea Important: If ite		21. Signature of Funeral Servi	èe Licensee		22. N	ame and Ad	dress o	of Facility	For	t Linc	oln Fun	era1	Home	
	Balti permit. Departu Import injury		Kila to the	G		3/	01 R1	ad as	ah	ma D	D D.	4 1 M	D 20:	722	
	ysician		23a. Part I. Enter the disease, failure. List only one cau	or complications that	caused the death.	Do not enter th	ne mode of d	lying, s	uch 'as ca	ardiac or	respiratory a	rrest, shock, or l	neart	Approximate Interval Between Onset and	
	/ledical			0 11	unexplained	death i	in child	lhoo	1					Death	
	Examiner		Immediate Cause (Final disea or condition resulting in death	Due to (or as	a consequence of):	deda.			100						
			O	b.											
		Jer	Sequentially list conditions, if any, leading to immediate		a consequence of):	:									
		mir	cause. Enter Underlying Cau (Disease or injury that initiate	., C.	s a consequence of)										
1	sit sit	Examiner	events resulting in death) La	st Due to (or as	s a consequence or,										
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	760, ficate be g physici the buri	Ĭ	IF FEMALE: 23b, Was decedent pregnant i	23c. If ye	s, outcome of pregna	ancy		3	Ectopia	c pregna	incv	Month		Day Year	
	68° ertifi ding	ian	past 12 months?	4 Pre	e birth egnant at time of dea	Ale T	ther (Specifi	_		- p 5	,				
	Box 68 e death certif the attending ed for use as	sic	1 Yes 2 No 9	University 1	known	0 0	mer (opcon,	" —				Ì			
	b. Box 68 the death certify by the attending ched for use as	Physicia	Part II. Other significant cor	nditions contributin	g to death but not re	sulting in the	underlying c	ause g	iven in Pa	art I.				to the cause of death?	
	that ned b	<u>چ</u>	-								1 🔲 🕻	Yes 2 No	3 Pr	obably 4 🗸 Unknown	
	Records, P.C The law requires that cate has been signed by	ed								_	24a. W			autopsy findings available	
	ord w req us bee	Completed						-			au pe	topsy rformed?	prior to death?	completion of cause of	
	ecc he la ute ha	E									1 ✔ Ye	s 2 No	1 🗸	Yes 2 No	
	T: T	l Ö	25. Was case referred to me	dical			26			(Check	only one)				
	Division of Vital Records, P.O. Box 68' spital or Attending Physician: The law requires that the death certificate that birsterior. After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as	Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatien	nt 3 DO	A	Other ₄	Nursir	ng Home 5	Residence	6 Oth	ner:	
	Phy Frhy ter th	<u>ا</u>	27. Manner of Death	28a. D	ate of Injury onth, Day,Year)	28b. Time of	Injury 28	c. Injur	y at Wor	k?	28d. Descri	be how injury oc	curred		
	nding h. Af	<u>6</u>	4 V Manual	Pending	onth, Day, Year)			1 \	es 2	No					
	Sior Attend death ector:	cat		nvestigation 28e. F	Place of Injury - At ho	ome, farm, stre	eet, factory,	office b	uilding, e	etc.			umber or i	Rural Route Number, City	
	Je affer Dir	Certification:	- Galaida	Could not be							or Tow	n, State)			
	Divis Hospital or A 24 hours after Funeral Dire	ပီ	4 _ Homicide	determined (Specify) ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									tated.		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carrier one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carrier one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carrier one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carrier one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carrier one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carrier one)									ate and place, a	ind due to	the cause(s)				
4	Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	one) 2 Medical	and mann	er stated.									Month, Day, Year)	
1		≥	29b. Signature and title of ce	e of certifier 29c. Licer					O.C.M.E. 29d. Date Septem					2007	
	1			UN	111			J.U.	. 4 4 4				-,		
L	5)		30. Name and address of pe	rson who completed	cause of death (Item	23a)	0:		4! no =	MO	1201				
/1				Deputy Chief Me	_		enn Stree	t, Bal	umb re ,	IVIU 2	1201				
		State	31. Date filed (Month, Day, Y	ear) 32	. Registrar's Signal	lle 1									
		_		/ / / / / / / / / / / / / / / / / / /	11.										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 29890 Thelma E. Callwood Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day August 24, 2007 Physician/ 1445 hrs Callwood E. Mardi∽al Examiner Thelma 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Suitland 3508 Parkway Terrace Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Davs Hours Director Feb. 25, 1943 64Yrs 056-48-4622 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No 23a or 28a-f show notified at once. Suitland PG Md. death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20746 3508 Parkway Terrace Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status items 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married it. Pages 1 and 2 should be flied within 72 hours after dearment of Health and Mental Hygiene.

range I fliem 27 is marked other than "

vr other traumatic even" 2 X No Yes Specify: Black 1 Yes 2 X No specify: If Yes, Give Year Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Private Nursing Assistant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barrett Be Daphne_ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kerwin Road ver Spring, Laurel M. James/sister Md 20901 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Riverdale Crematory 9/1/07 Important: injury or oth Riverdale, Md. permit. Page Department Donation 5 Other Specify: 22. Name and Address of Facility Hodges & Edwards F.H. Signature of Funeral Service Licensee 3910 Silver Hill Rd. Suitland, Md. 20746 2.3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Physician failure. List only one cause on each line. Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate ᆵ cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician for use as the burial 23d, Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth Fetal death 2 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? certificate has page 2 s 1 🗸 Yes 1 ✓ Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director. 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 DOA ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 3 Could not be Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 25, 2007 O.C.M.E. Outwarter. Kull 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

	- 25 mm		For State Registrar	State of Maryla			of Health and of Death	d Mental Hy	giene	1111/	29891			
	Physici /Medic	cal	Decedent's Name (First, Middle, L. Paul 4a. Facility Name (If not institution, gi	ollins		4b City To	wn, or Location of D	2. Date of D Month	3.5	Year O7 County of Death	3. Time of Death 5: 44 PM			
	Examir Funeral	ier	Washington Adv	entist	. last birthday)	Tak If Under 1	COMQ	Irs. 8. Date of 8	Pr	ince G	Place (State or Foreign			
- Ngr	Director		Usual Residence of Decedent	Sex, 12 M 2 F	Yrs.		ays Hours N	1 5 / 1 1	1/19	39 WAS	SH. DC			
	Be-f show	ector	10a. State 10b. County		ity, Town or Lo	ton I)C				10d. Inside City Limits 1 Yes 2 □ No			
	ath with ti	Funeral Director	1221 MSt. NW				0005			USA				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Evantinar must be redified at ancace.	<u>6</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 Yes 2	t of Hispanic Origin? Cuban, Mexican, Pi No <i>Specify:</i>	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ameri Black, White Specify: Black				
21215-0036	ad within 72 h rgiene. er then "netu i, the Medica	Completed	15. Decedent's E (Specify only highest g	rade completed) College (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use r	done during most of retired)		Au		ndustry			
Maryland	ould be file Mentel Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, M. BYACE COLLING											
	and 2 sh salth and n 27 is m		1	daughter	1011 E	rimler	the same of the same of	of Itelights	m	D 207	43			
Baltimore,	Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	□Removal from State	Place of Dispo cometery, cre-	matory or othe	r place)	PT 5,200	MA	Shing tor	D.C			
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Life	Mason	1 /	2. Name and A	Address of Facility FUNERAL	LService	58 R	or cleu	E MOZBO			
1	Physician		Part1. Ent in the dispase or conshock, or man fail relist ont interest is the disease or condition.	mplications that caused the dea y one cause on each line.	ith. Do not an	ter the mode o	f dying, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death			
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a conse	quence of): CDIAL	- INF	ARCTION	4						
	ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse										
8760,	icate be executed physician and s the burial-transit	cal	· ·		CELL	LOMA								
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23d. Date of deliv	very Day Year							
	uires that i signed by lid be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the						
Il Records,		Completed						peri	s an opsy formed? 2 🔀 No	prior to co	opsy findings available ompletion of cause of			
Vita	Physicien: r this certifice ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	7.500		Other	Death (Check only		0.5500				
Division of Vital	Attending Phy or death. ector: After this by the funeral d	ation: To	27. Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 Yes 2 No	ng Home 5 ☐ Res 28d. Describe			ny)			
Divis	or Dir ⊡	Certification:	3 Suicide 6 Could not 4 Homicide determine		reet, factory, o		28f. Location (Street and Number or Rural Ro City or Town, State)							
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical		Physician: To the best of my kraminer: On the basis of examinand manner stated.										
	To the within To the comp	Me	29b. Signature and title of certifier	MA			icense number			te signed (Month				
•	an		30. Name and address of person who	o completed cause of death (Ite	em 23a) (Type,	Print)	46529 TRKWAY	Corr	RCP	1431 BU	AND			
	Sta Registr		31 SEP 0 5 2007	32. Registrar's Sign	nature	URITI	1 Crown	y ruit	000	1 141111-10				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 31 Physician Cole 2007 A M Ernest August 2:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15247 Old Marlboro Pike Upper Marlboro
If Under 1 Year | If Under 24 Hrs. Prince George's 8. Date of Birth (Month, Day, June 9 5. Social Security Number 7, Age (In vrs. last birthday) **Funeral** 1**⅓**M 2□F Months Days Hours Min ^{Year)} 1928 79 Yrs. Maryland Director 215-20-3438 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Prince George's Upper Marlboro 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15247 Old Marlboro Pike 20772 U.S.A. filed within 72 hours after death Funera 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐ Yes 2**X** No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi: Department of Health and Mental Hygiens Important: If tem 27 is marked other tha any Injury or other traumatic event, the It 12th Bus Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Colbert Benjamin Cole ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2074719a. Informant's Name/Relationship (Type. Print) # 8 Upper Marlboro Pike Forestville, Maryland Tangela E. Cole/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sept. 8 2007 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Multi-or an Failure Sequentially list conditions, Examine It also be ding to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, attending physiciar Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) 0 signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown نے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 s has autopsy perform certificate 2K No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records,

To the Hospital or Attending within 24 hours after common to the Funeral Director: Aft

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's

20772 Arnulfo Bonavente M.D. 6409 S. Crain Highway Upper Marlboro, Maryland

1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D45630

29d. Date signed (Month, Day, Year)

August 31, 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien20071 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Sept. 1 2007 6:30 A M Joan Alice Coffey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1000 Hook Road Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Mooth, Day, Year Min March 24, 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 219-38-2182 64 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, the Mcdical Examiner must be notified at 1 ☐Yes 2 TXNo Completed by Funeral Director Carroll Westminster MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21157 U.S.A. 1000 Hook Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental Hitem 27 is marked others. Be Troy Frances Painter Cleo Blanche Lively husba...d9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 is
eny injury or other treu
once. Donald C. Coffey, Sr. 1000 Hook Rd. Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/3/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD South Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Myers-Durboraw Funeral Home M01191 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Von-SMALL CELL LUNG Immediate Cause (Final disease or condition resulting in death) CANCER Priysician 6 MONTHS /Medical Due to (or as a consequence of): Sequentially list conditions, flany, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No

Examiner The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. or Attending Physician:

Baltimore, Maryland 21215-0036

ours after death.

erel Director: After this certificate has filled in by the funeral director, page 2.9

24 hours a within 2 To the To the WIL 2

Medical

4 Homicide 29a. Certifier

1 🗌 Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29b. Signature and title of ceptifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00062254

Other: 4 Nursing Home Schemes 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

TNUICA, MD, SINAI HOSPITAL, 2401 BEEVED ENE AVIBAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

2 No

5 Pending investigation

6 Could not be determined

2007

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature General & Spark

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

07-06890 Dona

07-06890 Donald Class		State of Maryland / Department of Health and Mental H	lygiene	26	007 2989
	Da	or State Certificate of Death	Reg. 2. Date of Death	NO	3. Time of Death
Physician	1.	Decedent's Name (First, Middle,Last)	Month Di September 2	ay Year I, 2007	2100 hrs
Mee Examine		Donald Earl Class Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Deat	h
	48	Upper Chesapeake Medical Center Bel Air		Harford	
	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi		MM/DD/YYYY) 9. Bi Forei	ign 1
Funeral Director	- 1	Mortuis Days around in	Aug. 7	, 1958 ^c	ountry Maryland
Director	-	215-76-2225 1x M 2 F 49 H		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits
	_	Da. State 10b. County 10c. City, Town or Location			1 Yes 2 X No
L wol	. IN	aryland Harford Jarrettsville	0.70	644	
cyland	ᅙᇦ	De. Street and Number		. Citizen of What Co	untry?
the Mar	Director □	1403 Buckthorn Drive 21084		USA	Lutter Block
		1 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Organ Puels	Specify Yes or No- rto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
sath w	Funeral	Never Married 2 X Married Armed Forces?		Specify: W	White
		Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	of work done	16b. Kind of Busines	
urs ad	å⊦	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use of during most of working life.		ary granus till a select	me as a new transport makes and a south the state
72 hc	를	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Accountant/Owner-Ope	erator	Account	ing
036 rithin ene.	Completed	40 Mothor's No	ame (First, Middle, M		
5-0 led w Hygie othe		7. Father's Name (First, Middle, Last) Kathle	een Ellen	Mackessey	<i>I</i>
121 I be fi ental arkec	Be	RAYMONG EATT CLASS	or Rural Route Numb	per, City or Town, St	ate, Zip Code)
MD 2. d 2 should the and M n 27 is m. sumatic e	٢	Patricia H. Class / Wife 1403 Buckthorn Dri	ve, Jarre	ttsville,	MD 21084
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturall", injury or other traumatic event, the Medical Examines	ŀ	20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
of He	- 1	TO Chair Chair Clean Chair Place	9-7-07	Towson, I	Maryland
Page nent lant:	L	4 Donation 5 Other Specify:			
Baltimo permit. Pag Department Important:	- 1	/ // // // W/// / / / / **	DAI AIR	1411 / 1 / 1 / 1 / 4	
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	ac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Physician fedical	- 1	tallure. List only one cause on continue cardiovascular disease			Death
kaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		h			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	듩	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):			-
igi g /	Examine	events resulting in death) Last			
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க க ம	sician/Medical	#24,21,001,100		23d. Date of de	
30x 68760, death certificate be e e attending physicie I for use as the burit	N/W	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pr	regnancy	Month	Day Year
r 68 certi endin use a	cia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Box 68760, e death certificate by the attending physic ted for use as the burled for use as the burled for the	Ş	1 Yes 2 No 9 Unknown 9 Unknown	i. 23e. Did t	obacco use contribu	ite to the cause of death?
O. I at the d by t	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	1 Ye	s 2 No 3	Probably 4 🗸 Unknown
cords, P.O. law requires that the has been signed by 2 should be detach	d by		24a. Was	an 24b. We	ere autopsy findings available
rds requi been hould	ete		auto	psy pric	or to completion of cause of ath?
e law	Completed				Yes 2 No
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death. The law or After this certificate has been signed by leaf in by the funeral director, page 2 should be detac	ပိ	25. Was case referred to medical 26.Place of Death (C			
ital sician Is cert	Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA	Nursing Home 5	Trooldener -	Other:
Physer this	լ ⊢	27 Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?		e how injury occurred	1
VISION OF or Attending Ph. after death. Director: After ti	<u>.</u>	1 X Natural 5 Pending			Durte Number City
SiO Atter r dear ector by th	<u> </u>	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	. 28f. Location or Town,	(Street and Number State)	or Rural Route Number, City
Divisi Divisi pital or At ours after d	Certification:	3 Suicide 6 Could not be determined (Specify)			
Lospit Houn Houner Luner	51	1 X98. Certifier 4 Continue Division. To the best of the kilowiedge, death occurred at the	ce, and due to the ca	use(s) and manner a	is stated. ie to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	surred at the time, da		d (Month, Day, Year)
To Witt	No.	29b. Signature and title of certifier 29c. License number			
		his his, mp O.C.M.E.		September	0, 2001
110	/	30. Name and address of person who completed cause of death (item 23a)			
119		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	U1		
	_ Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Reg		SEP I O ZOO!			
	4 (000	OCME ORIGINAL			

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at any injury or other traumatic event, the Medical Examiner must be notifited at once.

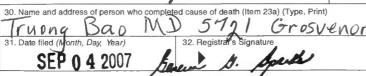
Physician /Medical Examiner

State Registrar			Certif	icate (of Death			. No2 0 (77	29895
. Decedent's Name (First, Middle		ZOM					Date of Death Month	^{Day} 20	Year 007	3. Time of Death
ANNABELLE a. Facility Name (If not institution	DIX		AL). City Tou	vn, or Location of De	-	UGUST	27 20 4c. County		8:50 p M
Suburban Hosp		ivel)		Bethe		Jaul			gome:	ry
Social Security Number	6. Sex	7. Age (In yrs. last bi	irthday) If	Under 1 Y	ear If Under 24 h		Date of Birth (Month, Day,)			place (State or Foreign
579-20-1664	1 □ M 2 🙀 F	95	Yrs.	lonths Da	ays Hours N	in. A	pril 17	,1912	Sout	h Carolina
sual Residence of Decedent Oa. State 10b. County		10c. City, Tow	vn or Location	on						0d. Inside City Limits
DC TOD. County		-	ingto							1⊠Yes 2□No
DC De. Street and Number		wasii		10f. Zip Co	de		109	g. Citizen of V	Vhat Coun	itry?
517 Somerset	P1 NW			•	0011		'	USA		
. Marital Status		dent Ever in U.S.	13. Was	Decedent	t of Hispanic Origin? Cuban, Mexican, Pi	(Specify	/ Yes or No-		e - Americ	
1 X Never Married 2 ☐ Marr		21 X No		es, specily Yes 2.23		uerio Mici	an, etc.)	Specify	ck, White,	eic.
3 Widowed 4 Divorced	Year or Da	ates:							B]	lack
15. Decedent (Specify only highe	t's Education st grade completed)	16a	a. Decedent (Give kind	t's Usual O d of work d	ccupation lone during most of etired)	working] 10	6b. Kind of Bu	usiness/Ind	dustry
Elementary/Secondary (0-12)	College (1		eamst		cureuj			Privat	e Fai	milv
12th T. Father's Name (<i>First, Middle,</i>	Last)	3	eams L	TESS	18. Mother's I	Name (Fi	irst, Middle, Ma			<u></u>
David Dixon	,				Carol					
9a. Informant's Name/Relations	hip (Type. Print)	198	b. Mailing A	ddiress (St	treet and Number of			City or Town,	State, Zip	Code)
Mary L. Taylor	/Niece	42	215 Hi	ldre	th St. SE	Wa	shingto	n,DC 2	20019	
a. Method of Disposition	о. Пр	20b. Place of cemeter	of Disposition	on (Name o	of r place)	Date) 20	0c. Location -	City or To	wn, State
1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State I		,	netery 9-	4-20	07 E	Brentwo	od,	MD.
1. Signature of Funeral Service	Licensee									
	NI I	20	Mar	ame and A				ıc.		
Jo IP.11	Parsha	ree	Mar 421	ame and A shal 17 9tl	ddress of Facility I's Funer h St. NW	al H	ome, Ir	ic. i, DC 2	20011	
3a. Party Enter the disease, or shock, or heart failure. List	Masha complications that complications	aused the death. Do	421	17 9t1	ddress of Facility I s Funer h St. NW	al H Was	ome, Ir hingtor	1, DC 2	20011	Approximate Interval Between
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11 State Reğistrar

SEP 0 4 2007

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

m 1)

29c. License number

20057124

29d. Date signed (Month, Day, Year)

8/28/07

			For State Registrar	State of t	viaryiano	Cer	tificate of	Death	vientai my	Reg. N	2007	298	396
	Physicia		1. Decedent's Name (First, Middle, II DANIELLE JUI	ŕ	IETEMA	N			2. Date of De Month	Da	ay Year 0 2007		Death M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town, o	r Location of Death			c. County of De		
			Suburban Hospita				Bethes		T		Montg		
	Funeral Director		116-74-9749	Sex 7. 1 □ M 2 🔀 F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	1f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec 15	ay, Year	988 Ne	rthplace (State of Country) W York	r Foreign
	and ww		Usual Residence of Decedent 10a. State 10b. County	-	10c. City	, Town or Lo	cation					10d. Inside Cit	ty Limits
	Maryl f sho	tor	GA Jenkins Millen									1 X Yes	2 □ No
	r 28a	Director	10e. Street and Number 10f. Zip Code 10g. 0								. Citizen of What Country?		
	th witl 23a o Ist be	aD	923 Wade St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican								USA		
	ems er mu	Funeral	11. Marital Status	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	14. Race - Am Black, Wh					
1924 Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 TaxNever Married 2 ☐ Married 1 ☐ Yes 2 TaxNo If Yes, Give 1 ☐ Yes 2 Tax No Specify: Year or Dates:							Specify: White			
5-0	72 h "natu	etec	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced	tent's Usual Occup kind of work done	pation during most of wor d)	king	16b.	Kind of Busines	s/Industry	
121	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 yr Student Univers								itv		
9	filed Hygie	ပ္တိ	17. Father's Name (First, Middle, La	18. Mother's Nam	s Name (First, Middle, Maiden Surname)								
<u>a</u>	ld be ental ked o	To Be	Paul Joseph Die	eteman II]	[Angel:	a Ellio	tt			
ary	shou and M s mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numl	ber, City	or Town, State	Zip Code)	
Ξ̈́	and 2 salth a 127 ls		Angela Elliott/N	lother			Wade St.			3044	2		,
Jue ore	of He of Her		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3	☐Removal from St	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other pla	ice)	Date	20c. l	Location - City of	r Town, State	
1934 altimore	Page ment ant: If		4 □ Donation 5 □ Other (Spe		Sou		Crematio				ans, GA.	·	
) / Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Lic	msh	nd		4217 9th	ss of Facility 's Funera St. N.W.	Washi	ngto	on, DC.	20011	
5			23a. 14 rt1. Enter the disease, or co shock, or heart failure. List or	mplications that cau	sed the death	n. Do not ent	er the mode of dyi	ing, such as cardiad	or respiratory	arrest,		Approximate Interval Bet	e ween
600	Physician		Immediate Cause (Final disease or condition					omyopathy				Onset and I years	
M	/Medical Examiner		resulting in death)		as a consequ								
AUG	LAGIIIIICI	-	Sequentially list conditions, Tany, leading to impresses. Due to (or as a consequence of)									3	
4	ted nsit	nine	Sequentially list conditions, if any, leading to inductate cause. Enter Underlying Cause (Disease or injury that initiated events Mitral Regurgitation										
30	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	V	as a consequ		• • • • • • • • • • • • • • • • • • • •						
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	rtifical ng phy as th	ledi	IS SERVALE.										
IEUL O. Box	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unk								23d. Date of delivery Month Day		
5 9	that ed by deta	y P.	Part II. Other significant condition	s contributing to dea	th but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	to the cause of d	leath?		
¥ sp	quires in sign	ed by							1 🗆] Yes	2 ∑ No 3□	Probably 4 □l	Jnknown
MAN DA or Vital Records	The law re te has bee age 2 sho	Completed							24a. Was auto peri 1∐ Yes	opsy form <u>ed</u> ?	death	— autopsy findings o completion of c ? es 2 □ No	available ause of
r /	lan: rtifica xtor, p	Be C	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)			
4 >	Physic this ce al direc	P	1 Yes 2 XNo	Hospital: 1 🔀 Ing	oatient 2	ER/Outpatier	nt 3□ DOA Ot	her: 4 Nursing H	lome 5□Res	sidence	6 □Other (Sp	pecify)	
	Ing Pl	ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury] Wo		28d. Describe	how in	jury occurred		
Sion Ci	r death. r death. ector: After this certifica	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	the -	f injuny - At ho	ime farm etr	M 1 []Yes 2∏No	28f Location	/Street	and Number or	Rural Route Nurr	nher
E/E	al or At s after c til Direc	Certification:	4 ☐ Homicide determin	ed building	g, etc. (Specify	y)	eet, factory, office		City or To	own, Sta	ate)	narai ricule ivuii	noer,
Dia	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		Physician: To the base	of examina								s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			,	1	se number	4.0		Date signed (Mo		
	5		Milis Feels	/ seerem	> /	0	2000	8107	141)	A	ug. 31,	2007	
OF			PHILIP CHARLES (C	RICHAN &	of death (Item	1 23a) (Type,	Print) ORCETUU	N AND	BET	TES/S	4,18	20614	
	Sta Registi		SEP 0 4 2007	See 32. Re	gistrar's Signa	oe de							

			Amended Item Plea Amend Items 23 La For State	19a per F ise Type or i,PtH _{3t} ate o	D. 09/0 Print in B Maryland					nty, I <mark>re Al</mark> and M	wj1 I Copie: Iental Hy	s Are /giene	Legible	÷.	0000	7 7
			Registrar			Ce	rtificate	of L	Death				200	1	2989	
ŀ	Physici	an	1. Decedent's Name (First, Midd Paul Kennet		•						2. Date of D Month	eath Day			3. Time of Dea	
	/Medic Examir		4a. Facility Name (If not institution Carroll Hospi	n, give street and nui	mber)		4b. City, T		Location o			4c.	County of D	-		
10	Funeral		5. Social Security Number	6. Sex 1 X M 2□ F	7. Age (In yrs. la		If Under 1	Year_ Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth lay, Year)	9.1	Birthpla Count	ace (State or Fo	reign
	Director		219-20-0118 Usual Residence of Decedent	IZIWI ZUT	81	Yrs.					Aug 2	3 192			MD	
	with the Maryland a or 28a-f show be notified at	tor	10a. State 10b. County	roll		, Town or Lo Taneyt								10	d. Inside City L 1 X]Yes 2[
	with the 3a or 28a st be noti	I Director	10e. Street and Number 153 Saddletop	Drive			10f. Zip (217	787			10g. Citi	izen of What USA	Count	ry?	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show lical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married ※ Mar 3 □ Widowed 4 □ Divorce	rried 1X Yes	ve 10	43	Was Decede If Yes, speci		ispanic Or in, Mexica Specify:	igin? (Span, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify:	/hite, e		
21215-0036	c - 3 0	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)	1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	done d retired	during mos I)	_			ind of Busine		_	
	filed withii Hygiene. other than	Son	11	L cot)		Fir	nancia	T 57			ent ∍ (First, Middle		York	ТТ.	e ins	
Maryland	a 7 5	o Be	17. Father's Name (First, Middle Edgar J. Dell	, Lasi)						a Bu	, .	e, ivialuen	<i>Surname)</i>			
aryl	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er once.	욘	Wildman Controllation	erri ^{Type. F} WT/fe	· · · · · · · · · · · · · · · · · · ·	19b. Maili	ng Address (Street a			al Route Num	ber, City o	or Town, Stat	e, Zip	Code)	
Z,	and 2 ealth a n 27 is	1	Wilda Condon/w	i_fo	1				<u> </u>		Taneyto					
Baltimore,	ages 1 nt of H : If iten		20a. Method of Disposition 1 □ Surial 2 □ Cremation		State	ace of Dispo emetery, cre				•	/2007		cation - City			
ıltin	nit. Praartmei ortant injury		4 □ Donation 5 □ Other (-		Krie	ders (and Cl		tminst P.A.		, MD	
B	permit. Departi Importi any inj		1/1/10								West				21157	
68760,	Physician and /Medical Examiner bhysician and sthe prival-transit	dical Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the state of the sta	a. Due to b	12	ence of:	10	F1	HO CERT		APPROVED BY	MEDICALE	XAMINER		Approximate Interval Betwee Onset and Dea	ih
P.O. Box 6	ath certi ttending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live b	tcome pf pregnar birth 2 □ Fetal nant at time of de own	death 3	⊒Ectopic pre ⊒ Other <i>(sp</i> e		,				23d. Date of Month		y Day Yea	r
	luires that the de n signed by the a lid be detached i	b	Part II. Other significant condit	ions contributing to d	eath but not resu	liting in the u	nderlying ca	use give	en in Part I	≥<-y				e to the	e cause of deat ably 4 □Unk	
al Records,		Completed	(R) Total	Secondary in	nfection (ue to	erthrit.	垂人 is	ST		24a. Wa aut per 1∐ Yes	opsy formed?	prior deat	to con h?	sy findings ava apletion of caus 2 No	
Division or Vital	r Attending Physician: Ther death. rector: After this certificate by the funeral director, pag	Certification: To Be	3 Suicide 6 Could	Hospital: 1 28a. Date (Monigation not be 28e. Place	·	ER/Outpatier 28b. Time of Injury	of 28	lc. Injur Worl	er: 4□Nı	ursing Ho	h (Check only me 5 Res 28d. Describe 28f. Location City or T	sidence how inju	ry occurred) Route Number	s
Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer		ing Physician: To the												
	To the within 2 To the comple	Mec	29b. Signature and title of certifi		mer stateu.		29c.	License	e number			29d. Da	te signed (M	onth, L	Day, Year)	
	1		Vinet	1 Oshow	reed () mc	\mathcal{I}	20	166	, 3		9	Ilile	7		
	ALLA		30. Name and address of person		se of death (Item	23a) (Type,	Print)				iocco,			•		
1	₹` Sta	te.	4+7 EAST 31. Date filed (Month, Day, Year		STARE E			W	ESTI	RIN	STER	m	2	115	7	
	Regist				Elm		book	,								

J7-06967 Jeffrey Scott Dilutis	
	1- For State Registrar Certificate of Death Reg. No. 2007 298
Physician	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 2.27 beau
Medical Examine	Jeffrey Scott Dilutis 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Franklin Square Hospital Rosedale Baltimore County
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	Monttis Days Hours Min. Foreign
	219-96-8400 1X M 2 F 36 Yrs May 6, 1971 Country) Mary Land
200	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
and Show	Maryland Baltimore Middle River 1 Yes 2 XNo
the Maryland a or 28a-f sh iffed at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
r death with or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 1 X Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, White, etc.
i, or i	
5-0036 ed within 72 hours after the within 72 hours after the with the with the with the wedical Examine Commission of the wedical Examine the wedical Examine the wedical Examine the with the wedical Examine the with the wedical Examine the with the wedical Examine the with the wedical Examine the with the wedical Examine the with the wedical Examine the wedical E	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
72 ho	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)
within ene.	12 Mechanic Automotive
15-(1 Hyging of 1 Hyging 1 Hyg	
2121 ould'be fi ould'be fi d Mental J s marked tic event,	Tom Henry Dilutis Margaret Mae Lockwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
AD 2 short and 1 sort is 127 is in matrice	Margaret Mae Thomas / Mother 1106 Stromko Drive, Fallston, Maryland 21047
Baltimore, MD 21215-0036 permit. Pages I and 2 shouldbe filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other treaumatic event, the Medical Examiner To Be Completed by	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
mor Pages ent of nt: If	T & Dullal 2 Oremation 3 Nemoval Iron State
mit. I	Donation 5 Other Specify: Meadowridge Mem. Park 9-12-07 Elkridge, Marvland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A.
M FORE	131/ Cokesbury Rd., Abingdon, Maryland 21009
Physician /Medical	23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
	b
9	Sequentially list conditions, If any, leading to Immediate Due to (or as a consequence of):
ed Insit	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
oe exection a cian a mial - 1	X UNPENDED — AMENDED 4.27,28a-f,perME,C871, 9/28/07 TT
box 68760, the death certificate be executed the attending physician and ched for use as the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live bitth Pay Year
certifications and ingress as as as as as as as as as as as as a	past 12 months? Live birth past 12 months? Pregnant at time of death Other (Specify) Month Day Year Other (Specify)
Box death death death	1 Yes 2 No 9 Unknown g Unknown
P.O. s that the gned by t detache	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the saft cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entitication: To Be Completed by P	1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires figate has been signage 2 should be Completed	24a. Was an autopsy findings available prior to completion of cause of
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tal I	25. Was case referred to medical examiner? Contact of Death (Check only one)
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n on or or or or or or or or or or or or or	27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred
isio	2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division o Spital or Attending sputal or Attending ours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 X Could not be determined (Specify) Franklin Square Hospital Baltimore, MD
Hosp 24 hou Fune stely fi	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit Medical Certification: To Be Completed by Physician/Medical Certification:	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	OCME
	Theodore M. his The way O.C.M.E. September 8, 2007
	30. Name and address of person who completed cause address (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	31. Date filed (Month, Day Vear) 32. Registrar's Singature
Registra	CED TR 2007 Apr. Secretal

State of Maryland / Department of Health and Mental Hygiene. 29899 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Michael Eller 2007 3:30 PM 28, August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28858 Adkins Road Wicomico Delmar Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1⊠M 2□F 54 Aug. 25, 1953 Director 214-62-9895 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Wicomico Delmar 10f Zin Code 10g, Citizen of What Country? 10e. Street and Number 28858 Adkins Road 21875 U.S.A. or Itams 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced "natural", Completed Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "na any injury or other traumatic aven". Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ Arnold A. Eller June Lucille Hagerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28858 Adkins Road 21875 Gloria J. Roberts (companion) Delmar, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 8-31-2007 Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licenses hulse Delmar, DE 23a. Part1. Enter the disease, of correlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Dav Year be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner weath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury s after dec. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Madeleine Estelle Flater August 29, 2007 3:42 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 2, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗙 F Hours Min. 86 216-80-4240 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Hampstead 1 ☐ Yes 2 No Maryland Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 3526 Basler Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by If Yes, Give Year or Dates: Specify. white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Marie Constantine Alfred George Max Schreck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3526 Basler Road, Hampstead, MD 21074 19a. Informant's Name/Relationship (Type. Print) James D. Flater, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pleasant Grove Cem. 9/1/2007 Finksburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01191 Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 K 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** nellmonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** C. A. J Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CHF physician and s the burial-trans Due to (or as a consequence of): Physician/Medical 0 attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 robably 1 ☐ Yes 2 ☐ No 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cate has b page 2 sl 24a. Was an autopsy performe 2 NA director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Demer (Specify) 10 VE 1 ☐ Yes 2111 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of HOWE 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice nours after death.

neral Director: After this

filled in by the funeral di

WIL 3

29a. Certifier

(Check only one)

Medical

Registrar

State

and manner stated.

29c. License number
D -0054218

29d. Date signed (Month, Day, Year)
08-30-07

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

cause of death (Item 23a) (Type, Print) Paleath duve, Westminsty MD 2/150 4 her aman 32. Registrar's Signature

SEP 04 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year AM 4:22 August 31 2007 Mary Jean Foster 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospitla Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 28 1926 9. Birthplace (State or Foreign Country) Maryland . Age (In yrs. last birthday) 1 □ M 2 □ F Yrs 81 213-24-8482 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes Ž□ No Hagerstown Maryland Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 135 Sunbrook Lane 21740 U.S.A. 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate Retail Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha N. Weaver Weller Edgar E. Weller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20401 Kings Crest Blvd. Hagerstown Maryland 21742 Phyllis J. Keliher - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State 9-4-07 Hancock Maryland 4 □ Donation 5 □ Other (Specify) Baptist Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Bld. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MASSIVE DAYS to (or as a consequence of): Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a donarduring of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3□ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

မ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me

72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

be

Examiner burial-transit physician the i for use as ed by the attending detached for use as signed to been this funeral After Certification: Pospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fu To the Hospital of within 24 hours af To the Funeral D

Physician/Medical \$ Completed Be

27. Manner of Death

1 🔀 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

JH-5

State Registrar

Medical

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

LOAD HAGENLYOWN MD

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1190 Mr VADIA GHALLALA

28a. Date of Injury

(Month, Day Year)

31. Date filed (Month, Day, Year) SEP 05 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** teven 00 August 2007 3 i /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hagerstown Washing County Hospita

7. Age (In yrs. last birthday) ton Washington 5. Social Security Number -6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F 53 Director 233-86-6160 5-1-1954 WVUsual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 TYes 2 X No To 101 04 Williamsport Pike
11. Marital Status
1 Never 11. Never 12 West Falling Waters WV Berkeley death with the 10g. Citizen of What Country? 10f. Zip Code 25419 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than ent, the Me Elementary/Secondary (0-12) 12 College (1-4or 5+) Carpenter Carpentry Pages 1 and 2 should be filed w treent of Health and Mental Hygie tant: If Item 27 Is marked other t jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ashby Fox Ruby Connor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Fox Item 27 I 10104 Williamsport Pike, Falling Waters25419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or any Injury or once. Rosedale Cemetery 9/4/2007 Martinsburg, WV 4 ☐ Donation 5 ☐ Other (Specify) 221 Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. <u>insburg,</u> WV Approximate Interval Between Onset and Death Pert . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, huck, or heart failure. List only one cause on each line. Immed te Cause (Final dis e or condition resulting in death) **Physician** Myscardial how /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) been signed by the s should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 s autopsy perfor Hospital or Attending Physician; ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 Yes a No 2 R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier D65488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pajman Danai 251 East Intictum St. gistrar's Signatu State

Registrar

20003

				Certificate	of Death		Reg. No.	J	29903
	1. Decedent's Name (First, Middle, Las	st)				2. Date of D	eeth		3. Time of Death
in al	CAROL	ANN GO	RSKY			AUGUST	. 31 20	Year)07	12:55 PM
ai er	4a Fecility Name (If not institution, give		NOICI		4b. City, Town,	or Location of Dee		of Death	
	EDWARD W. MCCREAD	Y MEMORIA	L HOSPI	TAL	CRISE	IFI D	SOM	1ERSE	:т
	5. Social Security Number 6. Se	ex 7. Age	e (In yrs. last bi	irthday) If Under 1 Y	ear If Under 24 h		irth	9. Birthi	place (State or Foreign intry)
	218-46-8456	□M 21X F	61	Yrs.	ays Tiodis II	AUGUST (7 1946	MARY	YLAND
	Usuel Residence of Decedent								4014 11 00 11 0
	10a. State 10b. County		10c. City, Tov						10d. Inside City Limits
ဥ	MARYLAND ANNE ARU	INDEL_	PAS	ADENA					1X Yes 2 □ No
	10e. Street end Number			10f. Zip Co	de		10g. Citizen of V	Vhet Cou	ntry?
<u>e</u>	8448 ARBUTUS ROAD)		2	21122		U.S	.A.	
Ē	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U,S.	13. Wes Decedent	of Hispenic Origin? Cuben, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)		e - Ameri	ican Indian, etc
豆.	1 ☐ Never Married 2 💢 Married	1 ☐ Yes 2 ☒ N If Yes, Give	ło	1□ Yes 2X		,	Specify		ITF
5	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Орвену	· WIT.	110
Be Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad	ucation de com <i>pleted)</i>	168	. Decedent's Usual O (Give kind of work d life. DO NOT use ri	ccupation one during most of	working	16b. Kind of Bu	usiness/In	ndustry
ğ	Elementary/Secondary (0-12)	College (1-4or 5	+)				DANIA	TNC	
င်္ပ		+2		MARKE			BANK		
9	17. Father's Name (First, Middle, Last)				18. Mother's f	Name (First, Middle	e, Maiden Sumam	10)	
0	FRANK OPALE	ENSKI	*		HELEN	TAYMAN			
	19a. Informent's Name/Retationship (7	ype, Print)	19	b. Mailing Address (Si	treet and Number or	Rurel Route Numb	ber, City or Town,	Stete, Zij	p Code)
	LAURENCE PAUL GORS	SKY SPC	USE 8	3448 ARBUT	US ROAD,	PASADENA.	MD 211	122	
	20a. Method of Disposition		20b. Place of	of Disposition (Neme only, cremetory or other	of	Date	20c. Location -	City or Te	own, State
	1 ☐ Burial 2 🛱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			CREMATORY		09/04/07	PARKSL	EY.	VIRGINIA
	21. Signature of Funeral Service Licens	See	1		ddress of Fecility	1			
	John of Willi	Miama (h	WILLIAMS F	UNERAL HOME	. 94 MARKET	ST., ONAN	VCOCK.	VA 23417
\dashv	22a Part 1 Hoter the disease or come	lications that caused	the death Do				1		Approximate
	23a. Part1. Enter the disease, or comp shock or heart failure. List only of	one cause on eech lin	ie.	TIOI BITTER THE INCOME OF	dying, such as care	diac of respiratory o	arrest,	h h	Interval Between Onset and Death
	Immediate Cause (Finat	Can	dian	Dry	shutin	10		1	11543
-1	disease or condition resulting in death)	e. CUPI	MUC	MI	1)41m	14			40 min
-		Calo	Due to (or es e	consequence of):	South	- Tril	1100		
		b. OUNC	16511	VE H	eari	7416	416		42415
VMedical Examine	Sequentially list conditions, if any, leading to immediate	100	pe to (or es e	consequence of):	andia	600001	246		V
8	cause. Enter Underlying Cause (Disease or injury	. 150	nem	10 a	iraio,	myor	14/119		years
을	that initiated events resulting in death) Last	12 "	Due to (or es e	consequence of):	4	* 1	~- 1	1	4
ž		d. Or	onal	ou fir	reres	Dise	use		Years
					_/			14	
	Part II. Other significant conditions co	ntributing to death bu	rt not resulting i	n the underlying caus	e given in Part I.	23b. Did	tobacco use cor	ntribute t	to the cause of death?
Dy Physicial	Atherosi	e rosis	5			1 🗆	Yes 2□ No	3 ☐ Pro	obably 4 Unknown
<u>`</u>	THE CITY OF	- 100.				_			
3							s en autopsy ormed?	av	ere autopsy findings vailable prior to
5						-			ompletion of cause death?
5						10	Yes 2000	1	□Yes 20 No
	25. Was case referred to medical		/		26. Plece of I	Death (Check only	one)		
	examiner?	Hospital: 1 ☐ Inpatie	nt 2 DERVO	utpatient 3 DOA	Other:	g Home 5□ Res		er (Speci	<i>ify</i>)
	27. Manger of Death	28a. Date of Injur	y 28b.		Injury et Work?		how injury occurr		
	1 Matural 5 ☐ Pending investigation		· ear)	Injury M	1 Yes 2 No				
	3 ☐ Suicide 6 ☐ Could not be	289. Piece of Inju	ry - At home, fa	arm, street, factory, of	fice		(Street and Numb	er or Run	al Route Number,
	4 ☐ Homicide	building, etc	. (эреспу)			City or 10	own, State)		
5	29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowledge	e, deeth occurred at the	e time, date end pla	ace, and due to the	ceuse(s) and ma	ınner as s	stated.
medical certification. To be completed	(Check only 2 Medical Exami	iner: On the basis of and menner ste	examination er	nd/or investigation, in i	my opinion, death or	ccurred et the time,	, date and place, a	and due to	o the cause(s)
É	29b. Signature and title of continer")	11		29c. Li	cense number		29d. Date signed		
- 1	NUVIVUVU	// V	11	0 0	no 110	102	0 0	7/	2002

State Registrar

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Physic: /Medi Examir

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Norma E. Bannister Gregoire /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13458 Lord Dunbore Place Upper Marlboro Prince If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State Country) Days Hours Min. 1 □ M 2 🖼 F 108-44-0959 **Director** 69 Jan 8, 1938 Barbados Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits at items 23a or 28a-f sh ner must be notified 1 X Yes 2 No Director MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13458 Lord Dunbore Place 20772 USA Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.
int: If item Z7 is marked other than "natural", or items 23.
Into the reaumatic event, the Medical Examiner must any or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify **Black** 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EKG Technician vears Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sewell T. Bannister Mignon Payne ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Waiters/Daughter 5905 Croom Station Rd. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 KCremation 3 Removal rom State Riverdale Crematory 9/3/2007 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 21. Signature of Funeral Service 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Athorosol erotte Cardiova disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the purial-tr Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as t IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Uriknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy perform certificate ha or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1☐ Yes 2☐ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1. Natural 5 Pending investigation ithin 24 hours after death.

the Funeral Director: Af
ompletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)
SEP 0 5 2007

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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MD

110 Hospital

32. Registra Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

040370

29d. Date signed (Month, Day, Year)

Prince Frederick md 20078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc 9871 9-18-07 yet.
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Month Helen Ε. Gaither 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) August 25, 1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 89 Maryland 217-05-7891 August Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MXYes 2 □ No Brunswick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21716 707 Brunswick Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married white 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Parkinson Roby Barbara Eckerd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22042 Barbara Desiderio - daughter 7001 Vagabond Drive, Falls Church, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 8-28-2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, Maryland e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part . Enter the dise shock, or heart failu Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) enmaniq - 3 We Due to (or as a consequence of):

Physician /Medical **Examiner**

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai

Physician

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Examiner

Funeral

Director

an "natural", or Items 23a or 28a-f show Medical Ex-miner must be notifled at

Baltimore, Maryland 21215-0036

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Be Completed by Physician/Medical Examiner ed by the aftending physician and detached for use as the burial-transit signed to funeral director Certification: To this To the Hospital or Attendii within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

law requires that the death certificate be executed

Division or Vital Records, P.O.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Juscase or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): C Due to (or as a consequence of): d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Congertin K		co use contribute to the cause of death? 2 No 3 Probably 4 Hunkhown 24b. Were autopsy findings available prior to completion of cause of
25. Was case referred to medical examiner?	performe	d? death? 1 Yes 2 No
1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Hepatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how	

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier cations

and manner stated.

29d. Date signed (Month, Day, Year) AVEUST 28, 200) 0 (8019

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21740 MAGERSTOWN のみててた MILL ST 340

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 2 9 2007



Division or Vital Records, P.O. Box 68760.

To the Hospius.
within 24 hours after
To the Funeral Dir

State Registrar

Medical

SOICONLOWO,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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29c. License number

29d. Date signed (Month, Day, Year)

09.02.2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HILL RD, \$507, OXON HILL, \$md 20745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dorchester Co. Health Dept. Plea Amended 23a, part II 9/7/07 eks State of Maryland / Department of Health and Mental Hygiene added colon carter per physcian Reg. N2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Stanley Gencel, Sr. Sept 2007 2:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis HealthCare - The Pines Talbot Easton 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Star County)
June 18, 1921 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 213.10.6395 86 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f abor other traumatic avant, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Dorchester Hurlock 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6602 Cabin Creek Court 21643 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic avant, the Mudical Examinations. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Correctional Officer Public Safety 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julius Gencel Leokada Povarski Gence. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Harrison Gencel/Spouse 6602 Cabin Creek Court, Hurlock, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 9.5.2007 Humlock, MD P.A. PO Box 43 216 North Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Hosee Herren Gonevill 23a. Th.1. Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Physician mouth /Medical Examiner metiva polynonem disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-translt Due to (or as a consequence of): Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 2 X No 1□ Yes colon cancer or Attanding Physician: 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) Certification; To nours after death. Ineral Director: After this y filled in by the funeral di 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 MICHAEL (ROWLEY MA CHMANS 0 4 2007 State Registrar

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	lealth and Death		iene _{eg. No.} 2 (007	299	909
4	Physicia	an.	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	h Day	Year	3. Time of I	Death
	Physicia Medic/		HOWARD ROBERT HOL			I		August		007 v of Death	6:35	a ^M
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100	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	ocation				10	d. Inside Cit	v Limits
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	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	a Di	4411 29th Street	:		2071	2		U.S.A			
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)	14. Ra	ack, White, e		
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ם,	Health Health tem 27 i		Armeldia Marshall 20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of or other place	1	Mount Rai	20c. Location			
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	Physician /Medical Examiner	iner	234. Part1. Enter the disease, or com shock, or heart failure. Last only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause, Oisease or injury	a. Due to (or a a connect Due to (or a a connect Due to (or a connect)	(juence of):	a Iuin	1	emone	1		Approximate Interval Bet Onset and I	ween Death
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0	Physic this cal dire	5	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1X Inpatient 2 28a. Date of Injury	28b. Time	ont 3 DOA Oth	4 Li Nuising	Home 5 ☐ Resid			y)	
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DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not b 4 Homicide determined		lome, farm, si ify)	treet, factory, office		28f. Location (S City or Tow		mber or Rura	l Route Nun	nber,
	ne Hospit n 24 hour ne Funera	edical	29a. Certifier (Check only one)	nysician: To the best of my kn niner: On the basis of examin and manner stated	owledge, dea ation and/or i	th occurred at the tinvestigation, in my	ime, date and pla opinion, death oc	ce, and due to the courred at the time,	cause(s) and date and plac	manner as s e, and due to	tated. the cause(s)
	To the within 2 To the complex	Ž	29b. Signature and title of certifier			29c. Licens	se number	1	29d. Date figi	ned (Month,	Day, Year)	
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	Domint.	ate	SEP 0 4 2007	32. Registrar's Sign	berte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Hughes August Jane Daisy 30 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Plata harles Medical Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) May 10, 1927 If Under 1 9. Birthplace (State or Foreign Social Security Number 226-36-0161 7. Age (In yrs. last birthday) **Funeral** Days Months North Carolina 1 □ M 2 ▼□ F 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Fort Washington Prince Georges Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20744 6307 Bentham Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Dais $\forall \mu \beta he$ Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Child Care Provider Federal Government Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hallie Boyd James Nunnally 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6307 Bentham Ct., Ft. Washington, MD 20744 Leilani Langford - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/2/2007 Edgewater, MD 4 Donation 5 Dother (Specify) 21. Signatur Juneral Sovice Licenses George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction HOURS **Physician** /Medical Due to (or as a consequence of): Hypertens con Years **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2 🗓 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à peripheral vascular 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No hyperlipidemie 24a. Was an autopsy performed? 1□ Yes 2☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical empletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. P. Sindbur 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier.

State Registrar

DHMH 17 Rev 1/2001

11350

Pem brooke

Square State 304 Walderf, MD 20603

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEY 0 5 2007

Sindhwani MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. 2.00 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 3:45 PM JULIA HOLMES 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CITY PRINE GEORGES RIVERDALE, MARYLAND CRESCEUT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month | Days | Hours | Min. | May 11, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 20 F 578-50-3970 69 Washington, DC Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examinating the notified at ans 10b. County 10c. City, Town or Location 10d. Inside City Limits ₹ Yes 2 No Directo Maryland Prince George's Riverdale 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4409 East West Highway 20737 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 years College (1-4or 5+) Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Richard Tucker Erma Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jacqueline R. Holmes - Daughter 4435 E Street, SE #4 Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee's Crematory Clinton, MD ^¹ 4 □ Donation 5 □ Other (Specify) Sept. 7, 2007 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Fune Service Lio ns 14001 Benning Road, NE Washington, DC 20019 23a. Part it filer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician A CUTE MYOCARDIAL NFARCTION 30 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Wementia 1 Yes 2 No 3 Probably 4 ØUnknown been sig Completed HYPERTENSION 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has DIABETES 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 8130107 D-25914 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.P. BRIMEN 4409 East West Highway Riverdale. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 2007 Registrar

07-06741 Randy Hafner

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29912

	1- For State		Certific	ate of E	Death			leg. No.	3. Time of Death
Physician/	1. Decedent's Name (First, Mid		fner				2. Date of Dea Month August 3	Day Yea 0, 2007	1825 hrs
	4a. Facility Name (if not instituted) Mt Zoar Road		er)		. City, Town, or Lo Conowingo	cation of De		4c. County C	
Funeral Director	5. Social Security Number		Age (In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hours	din	inth(MM/DD/YYYY)	9. Birthplace (State or Foreign Pennsylvani Country)
Mus	189-66-4661 Usual Residence of Decedent 10a. State 10b. Count		10c. City, Town						10d. Inside City Lir
≥	Pennsylvania I	Lancaster			Peach Bo		4	10g. Citizen of W	
permit: Pages 1 and 2 should be filed within 72 nours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Completed by Funeral Director	11. Marital Status 1 X Never Married 2	Married 12. Was Decede Armed Force 1 Yes	ent Ever in U.S.	If Yes	Decedent of Hisp s, specify Cuban,	Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	No- 14. Rac	te - American Indian, Black, ite, etc.
72 nours after d n "natural", or al Examiner m eted by F	4 Docedent's Education (5	12) College (1-4		a. Decedent' during mo	Yes 2 X No s Usual Occupation st of working life. Instructi	on (Give kind DO NOT use	retirea) .	16b. Kind of B	Business/Industry nstruction
be filed within 72 nour ntal Hygiene. rked other than "natu ent, the Medical Exar Be Completed					1	8.Mother's N	lame (First, Middle Christi	e, Maiden Surnam ne Lex	ne)
id 2 should, be alth and Ment m 27 is mark aumatic even	2 19a. Informant's Name/Relati Christine Lex		20b. Plac	8301 F	residents	Drive,	r or Rural Route N Hummelstov Date	n, Pennsyl	own, State, Zip Code) 1vania 17036 on - City or Town, State
oermit: Pages 1 and 2 she Department of Health and Important: If item 27 is injury or other traumati	4 Donation 5 Othe	ation 3 Removal from	crem	natory or oth	erplace) e Cremat	ory 0	9/07/07		erstown, Pennsylv
permit: Depart Depart Import injury	21. Signature of Funeral Ser 23a. Part I. Enter the disease	e, or complications that cau	used the death. Do	Le	ee A. Pai	terso Mar	n & Son yland 2 diac or respiratory	Funeral 1903-076 arrest, shock, or l	Home, P.A. 66 heart Approximate In Between Onse
vsician ical xaminer	failure. List only one ca Immediate Cause (Final disc or condition resulting in dea	ause on each line. _{ease a.} Multiple Injui							Death
p sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initial events resulting in death) L	euse c.	consequence of):		27	ХФ	llow .		
executian and ial - tra	UNPENDED IF FEMALE:	d. AMENDED	utcome of pregnal	ncy				l l	e of delivery
e death certificate be the attending physic ed for use as the bur	past 12 months?	t in the 1 Live bi	rth ant at time of death	2 F	etal death 3 ther (Specify)	Ectopic	oregnancy	- Monti	·
w requires that the de s been signed by the should be detached f	Part II. Other significant co			ulting in the	underlying cause	given in Pan		Yes 2 🗸 No	ontribute to the cause of dea
12 ha	Completed						<u> </u>	Was an 24 autopsy performed? Yes 2 No	4b. Were autopsy findings average prior to completion of caudeath? 1 Yes 2
certificate						Loui	Check only one)	- Decidence	6 Other: Scene
Of VICE ng Physicis After this ce uneral direc	examiner? 1 Ves 2 N	28a. Date	of Injury 2	R/Outpatier 28b. Time of FOUND:	Injury 28c. In	ury at Work?	Operato	ribe how injury or	
DIVISION OF VICEN NECTOR DIVISION: The Dours after death. eral Director: After this certificate filled in by the funeral director, page	Natural 5 2 Accident 3 Suicide 6 4 Homicide	Investigation Aug 30, Could not be	e of Injury - At hor	1812 hrs ne, farm, str	eet, factory, office		28f. Loca	tion (Street and N lwn, State) Road, Conowin	Number or Rural Route Numb
To the Hospital within 24 hours of To the Funeral completely filled		ving Physician: To the best at Examiner:On the basis	Major Road st of my knowledge of examination and	- dooth ooo	urred at the time	date and pla	ice, and due to the	cause(s) and ma	anner as stated.
To the within 2 To the Complete	29b. Signature and title of	and manner s	stated.		29c. Lice	nse number		29d. Date	e signed (Month, Day, Year) t 31, 2007
2	30. Name and address of Ling Li, MD As	person who completed cau ssistant Medical Exa	se of death (Item :	^{23a)} Penn Str	eet, Baltimore	e, MD 212	201		
St Regist	ate 31. Date filed (Month, Day	2007 Brown	egistrar's Signatur	Gode					
HMH 17 Rev 1/20	- 17	OCME		ORIGIN	IAL				

Security Officer

Government

21914

18. Mother's Name (First, Middle, Maiden Surname)

Emma Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

344 Market Street, Charlestown, Maryland

Suffe # 3 ELECTION MARTHAND

filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at Baltimore, Maryland 21215-0036 "natural", permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I once. 1 - State Registrar

10a. State

12

17. Father's Name (First, Middle, Last)

William C. Henry

19a. Informant's Name/Relationship (Type. Print)

Elizabeth M. Henry / Wife

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North

304-306

GAN-FL

Year)

0 5

31. Date filed (Month, Day,

Director

Funeral

Completed by

Be

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai physician and the within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

	20a. Method of Disposition	20b. Place of Disposition (Na cemetery, crematory or	ame of other place) Sept	ember 20c.	Location - City or	Town, State
	1 → Burial 2 □ Cremation 3 □ Removal from 5 4 □ Donation 5 □ Other (Specify)	Charlestown			r1estown	, Maryland
	21. Signal e Funcial Service Licensee	22. Name a	and Address of Facility Cr	ouch Funer	al Home	
	1/2000		uth Main Stre	•	East, Ma	ryland21901
	23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on each	aused the death. Do not enter the mo ach line.	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition a.	OCALDIAL INFAME	TION			Hours
	resulting in death) Due to (or as a consequence of):				
miner		or as a conse juence of).	DISEASE			YEAKS
al Exar		(or as a consequence of):				
Completed by Physician/Medical Examiner	23b. Was decedent pregnant		specify)			Day Year o the cause of death?
d b				1 ☐ Yes	2 ₽ Ño 3□P	Probably 4 ☐ Unknown
omplete				24a. Was an autopsy performed' 1 Yes 2 ✓	? death?	
Be C	25. Was case referred to medical		26. Place of De	ath Check onl one		
To B	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatient 3 0	OOA Other: 4 Nursing I	Home 5 Residence	6 ☐Other (Sp	ecify)
tion: 1	27. Mann Death 1 Natural 5 Pending (Mon 2 Accident investigation	of Injury 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
ertifica	3 Sulcide 6 Could not be determined 28e. Place buildi	e of injury - At home, farm, street, factoring, etc. (Specify)	ory, office	28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
Medical Certification:	29a. Certifier 1 CertifyIng Physician: To the (Check only one) 2 Medical Examiner: On the band man	e best of my knowledge, death occurre pasis of examination and/or investigationer stated.	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier	2	29c. License number		Date signed (Mor	
	b a no		11554000	Se	otenber:	1,2007

State

Registrar

6+/VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 29914 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 30, 2007 Physician George Dawson Hinshelwood 11:15 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | Year | Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (June 24 Hrs. | Months | Days | Hours | Min. | June 26, 1924 | West Virginia Holy Cross Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 1**X** M 2□ F 232-42-2774 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at tXXYes 2 □ No Completed by Funeral Director Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3906 Underwood Street 20815 United States or Items 23a Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Modical Examinations. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Aerospace Engineer Goddard Space Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be J. V. Hinshelwood ဥ Clarissa Moran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Hinshelwood / Wife 3906 Underwood St. Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State National Crematory 09/01/2007 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) O 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Fungral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 ulu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-translt Dehydration Due to (or as a consequence of): Physician/Medicai attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an page 2 s autopsy performe 2 🗷 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ٩ 1 Inpatient 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident To the within 24 hours to the Funeral Director 'stely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29s Certifior Medical K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the name(a) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D65305

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records. death. hours after death uneral Director;

death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Farhat Khan MD 1500 Forest Glen Rd. Silver Spring, MD 20910

31. Date filed (Month Pan Year) 2007

32. Paistrar's Signature

H. Sporte

08/30/2007

Examin		13408 Clifton R		- 4				Spring	las:		Montgo	
uneral rector		5. Social Security Number 011-40-7261 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2X F	ge (In yrs. Ia 92	Yrs.) If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da Dec 2	ay, Year)	914 9. Bi	irthplace (State or Fo Country) FRANCE
f show ed at	ō	D.C. Non	-		Town or L	ocation	D C					10d. Inside City L
or 28a-	irec	10e. Street and Number	ie	VV	asiiiii	10f. Zip C				10g. Citiz	zen of What C	Country?
23a c ust be	ra 🗆	3312 35th St., 1	N.W.				2001	6			USA	
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	•	3. 13.	Was Deceder if Yes, specify 1 ☐ Yes 2		nic Origin? (Sp Mexican, Puerto pecify:	pecify Yes or No Rican, etc.)		Black, Wh	erican Indian, ite, etc. White
n "natura Aedical E	Completed	15. Decedent's (Specify only highest	s Education grade completed)	1	16a. Dece (Give life.	edent's Usual (e kind of work DO NOT use	Occupation done durir retired)	n ng most of wor	king	16b. Kir	nd of Busines	s/Industry
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vent,	Be	17. Father's Name (First, Middle, L	ast)				18.	Mcther's Nam	e (First, Middle	, Maiden	Surname)	-
harke hatic (卢		Jean Ebrard		T				e Baron			
er traum		19a. Informant's Name/Relationshi Deborah Hastings		ghter	I				ral Route Numb shingto			
P e le		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Meti	ace of Disp metery, cre copol: emato:	osition (Name ematory or othe itan	of er place)	Aug,	31, 007,		cation - City o andria	r Town, State , Virginia
Importa any inju once.		21. Signature of Funeral Service L	icensee		2	2. Name and		Facility De	Vol Fun			20007
100		23a. Pa 1. Enter the disease, or of the control of	complications that caused	d the death.				-			1., D.	Approximate Interval Between
ician dical niner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Failure Due to (or as b. Alzheim Due to (or as	a conseque er [†] s a conseque	ence of): Disea ence of):							
certificate has been agreed by the attentioning physician and rector, page 2 should be detached for use as the burial-transit	sician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as d	pf pregnan	ncy death 3	⊒Ectopic preg ⊒ Other <i>(spe</i> c				2	3d. Date of do	elivery Day Yea
ached	Physi	1 □ Yes 2 ☒ No 9 □ Unknown	9□Unknown		uui 01							
onld be de	by	Part II. Other significant condition	ns contributing to death b	ut not resul	ting in the u	ınderlying cau	se given in	Part I.				to the cause of deat Probably 4 XUnki
r, page 2 sh	Completed										24b. Were a prior to death? 1 □ Ye	
directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatie	ent 2∏F	R/Outnatie	nt 3□ DOA			th (Check only o		M Other (0-	Group ecify) Home
completely filled in by the funeral director,	- 1	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ıry	28b. Time o Injury		. Injury at Work?	2 No	28d. Describe			ecny) House
led in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	building, et	c. (Specify)					City or To	wn, State)		Rural Route Number
oletely fil	Medical	29a. Certifier 1 ⚠ Certifying (Check only one) 2 ☐ Medical E	Physician: To the best xaminer: On the basis o and manner st	t examinati	rledge, dea on and/or in	th occurred at ovestigation, in	the time, on my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
3 2	ž	29b. Signature and title of certifier				29c. L	icense nu	mber		29d. Date	e signed (Mor	nth, Day, Year)

			For State Registrer	State o	of Maryla		artment of H tificate of L		/lental Hy	giene Reg. 2	007	29916
	Physici /Medic		1. Decedent's Name (First, Middle, La Ollie Mildred	_{st)} Hartma	n				2. Date of De Month Augus	Day	, 2007	3. Time of Death 5:30 p M
	Examin		4a. Facility Name (If not institution, give Redford Court Nu					Location of Death		4c.	County of Dea Mon	tgomery
	Funeral Director		239-44-5891	6ex I□M 212TF	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 4,		Co	thplace (State or Foreign buntry) h Carolina
	72 hours after death with the Maryland natural, or items 23a or 28e-f show Ircal Examinar must be molified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montg	omery	10c. C	Silv	er Spring			40- 0''	(115)	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 23a or 3	rai Dir	3500 Forest Ed			110	10f. Zip Code	20906	- 4. V		zen of What Co US 14. Race - Ame	A
980	urs after de al', or item	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Tyes If Yes, Gir Year or D	2 TNo	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ⅓No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.))-	Black, Whit	e, etc.
21215-0036	permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be refulled at once.	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12) 12	ducation ade completed) College ((Give	dent's Usual Occupa kind of work done o DO NOT use retired nemaker	luring most of work	ing	16b. Ki	of Business	·
and	d be filed antal Hyg ced othe c event,	o Be C	17. Father's Name (First, Middle, Last Columbus Harris		s			18. Mother's Nam	e (First, Middle ie Mae		Sumame)	
Maryland	nd 2 shoul Ith and Me 27 Is mark	To	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir		and Number or Run	al Route Numb	er, City o	Town, State, 2	Zip Code) 20906 r Spring, MD
Baltimore,	Pages 1 arent of Heannt: If item		20a. Method of Disposition 1 🏝 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Special			cemetery, crer	sition (Name of natory or other place an's Ceme	g) Sant			cation - City or	Town, State Marvland
Balti	permit. Departm Importer any inju		21. Signature of Funeral Service Lice		1		Name and Addres	s of Facility Collins	Funera	l Hor	ne Inc.	ng. MD 20901
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a My	each line. ocardia	ath. Do not ent	er the mode of dying				ar ogar	Approximate Interval Between Onset and Death Minutes
50,	Examine be executed by sician and burial-transit site burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Co:	ronery (or as a conse	Artory quence of):	Disease					Years
P.O. Box 68760,	death certii e attending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ointh 2 🗆 Fet nant at time of	tal death 3	Ectopic pregnancy Other (specify)		-	2	23d. Date of del Month	ivery Day Year
	es De	by	Part II. Other significant conditions	contributing to d	eath but not re	sulting in the u	nderlying cause give	en in Part I.				the cause of death?
Vital Records,	The ate h page	Completed		<u> </u>			<u>-</u>		24a. Was auto perfo 1 🗀 Yes	osy ormed?	24b. Were au prior to death?	utopsy findings available completion of cause of 2 No
i Vita	Physician: Th r this certiticate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	∃ER/Outpatien	t 3□ DOA Othe	26. Place of Deat			Other (Spe	cify)
Division of	fung After	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be	n	of Injury th, Day Year)	28b. Time of Injury	28c. injury Work M 1 \(\)		28d. Describe			
DIX	itel or Attendins after death		4 Homicide determined	286. Place build	ing, etc. (Spec	ify)	eet, factory, office	Į.	City or To	wп, State,)	ural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medicai	one) 21 Medical Exam	niner: On the b	e best of my kn asis of examin ner stated.	nowledge, death nation and/or inv	occurred at the time vestigation, in my op	inion, death occur	and due to the red at the time,	date and	place, and due	to the cause(s)
}	5 Suith	Σ	29b. Signature and title of certified	W	1 W.	Δ ,		8457			e signed (Mont Just 31,	
			30. Name and address of person who Nakul Goyal M.I	380	01 Inte	rnation	nal Drive		Spring	, MD	20906	
	Sta Registr	- 4	31. Date filed (MontSEPYear) 4	2007 32. F	Mistrar's Sign	diature .	andi					

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

2007

14. Race - American Indian,

Black, White, etc.

Specify: White

:30P

Birthplace (State or Foreign Country)

DE

10d. Inside City Limits

Approximate Interval Between Onset and Death

cens

1 ☐ Yes 2√ No

SA5

Holloway, Charles

38

State Registrar

31. Date filed (Month, Day, Year! SEP 05

chder

who completed cause of death (Item 23a) (Type, Print) egistrar's Signature

			riease i	State of Manua	nd / Don	aenik	ne ink. Ensure A	Montal Hygia	e Legible.	
			1 - For State Registrar	State of Maryta	Cei	arume rtifica	ent of Health and I	vientai mygie Reg.		29918
	Division		1. Decedent's Name (First, Middle, Last)			_		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Louise Ann Harris	-				Septembe		8:51 A. ^M
	Examin	er	4a. Facility Name (If not institution, give s			4b. Ci	ty, Town, or Location of Death	1	4c. County of Deat	h
			Garrett County Me 5. Social Security Number 6. Sex		tal last birthday)		akland der 1 Year If Under 24 Hrs.	9 Date of Birth	Garrett	holoo /State or Foreign
	Funeral Director			M 20XF 67	Yrs.		ns Days Hours Min.	8. Date of Birth (Month, Day, Ye March 19		hplace (State or Foreign untry)
			Usual Residence of Decedent	07		!		march 19	1940 New	York
	how	_	10a. State 10b. County	10c. C	city, Town or Lo	cation				10d. Inside City Limits
	Ba-f.	Director	MD Garrett	0	akland					1 ☐ Yes 2 🔀 No
	with th	E C	10e. Street and Number				Zip Code		Citizen of What Co	
	eath v	by Funeral	2310 Paradise Poi	nt Rd. 2. Was Decedent Ever in	119 12		1550		nited Sta	
	fter d	F	1 Never Married 2 Married	Armed Forces?	0.3.	f Yes, s	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whit	
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗀 Yes	i 2⊠ No Specify:		Specify:	Thite
2-0	within 72 hours after death with the Marylend ene. then "neturel", or Iteme 23e or 28e-f show the Madical Exeminer must be multind at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's U	sual Occupation work done during most of wor	tking 16t	. Kind of Business/	
2	Athin hen hen	du du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NO:	Tuse retired)			
7	lled v lygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)		Admi	nis	trative Assist	tant ne (First, Middle, Mai	N.I.H.	
and	d be f	Be	Charles Peters					chlobohm	oen sumame)	
Maryland 21215-0036	should Me Me mark	ပ္	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	na Addre	ess (Street and Number or Ru		ity or Town, State, 2	Zip Code)
S	nd 2 :		Mr. Richard Harri				radise Point 1			
Je,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-f show any nurry or other treumatic event, the Madical Examiner must be notified at an once.		20a. Method of Disposition	20b.	Place of Dispo			Colonia de la co	. Location - City or	
Ĕ	Page nent o		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State			l l	5/07 C	umberland	, MD
Baltimore,	apartr sports sy nje		21. Signature of Funeral Service License				and Address of Facility VId A. Burdocl			
_	80559		Katherine Su	reits		21	N. Second St.	Oakland	. MD 2155	0
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea e cause on each line.	ath. Do not ent	er the m	lode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Hemorhagi		:e				2 months
	/Medical Examiner		Tooking in addition	Due to (or as a conse		n		.1 D4		140.44
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		Pe	ripheral Vascu	llar Disea	se	years.
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
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3760,	cate be ohysici the bu	ical	d							
x 68	entifica ling ph e as th	Med	IF FEMALE:							
Вох	eath certific ettending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe	tel death 3		pregnancy		23d. Date of del Month	ivery Day Year
o O	he de / the c	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	geath 5	Other	(specify)		-	
Division of Vital Records, P.O.	The law requires that the death certifica ste has been signed by the ettending ph page 2 should be detached for use as tr	by Physician/Medi	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlyin	g cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	n signe		Alcoholic Hepat	itis				12 Yes	2 🗆 No 3 🗆 Pr	obably 4 🗆 Unknown
၀	aw require s been sign	Completed	Chronic Bronchi	tis				24a. Was an	24b. Were au	utopsy findings available
<u>~</u>	The lav	E						autopsy performed 1 ☐ Yes 2 ☑	1? death?	comptetion of cause of 2□ No
ita	sien: Brtific ctor,	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)		
5	hysik this c	၉	1 ☐ Yes 2 ☐ No H	ospital:				lome 5 Residence		cify)
ב	Jing F	lon:	27. Manner of Death 1 □ Hatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work?	28d. Describe how i	injury occurred	
<u>.</u>	Attending Physicien: or deeth. ector: After this certifice by the funeral director, i	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm str		1 Yes 2 No	28f. Location (Stree	t and Number or Ri	ral Route Number
<u> </u>	after after Direction by	Certification:	4 Homicide determined	building, etc. (Spec	cify)	001, 1401	ory, omos	City or Town, S		
	To the Hospital or Attending Physicien: The within 24 hours after deeth. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	- C	29a. Certifier 1 Certifying Phys	ician: To the best of my kr	nowledge, death	occurr	ed at the time, date and place	, and due to the caus	e(s) and manner as	stated.
	the Hi in 24 the Fi	Medic	one)	and manner stated.	ation and/or in	vestigati	on, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier			1	29c. License number	29d.	Date signed (Mont	h, Day, Year)
,	12						1717 777		11416)
			30. Name and address of person who co				r Cololond M	21550	, , , ,	
	Sta	te	Dr. Thomas G. Joh 31. Date filed (Month, Day, Year)	nson, 311 N. 32. Registrar's Sign	nature	ree	L, Uakland, Mi	21330		
	Registr			007		Speed	60			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 RUTH POWELL JOHNSON AUG. 27 2111 p^M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY Shady Grove Adventist Hospital Rockville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 28,1939 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 □ XF 67 West VA 578-64-7643 Usual Residence of Decedent 10b. County 10c. City Town or Location 10d. Inside City Limits Montgomery Germantown 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 12612 Grey Eagle Court, #24 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sunrise Assisted Elementary/Secondary (0-12) College (1-4or 5+) vrs Care Manager Living 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ennis Powell Vera 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21405 Woodfield Rd, Gaithersburg, MD 20882 Kim Gaither (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1√ Burial 2 □ Cremation 3 □ Removal from State 9/4/07 Ressurection Cem Clinton, MD 4 Donation 5 □ Other (Specify) 21. Sg | cure of Funeral Servic Lin ns 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death disease or condition resulting in death) Years Athersclorotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions. Dual to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

attending physician certificate be

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has

this certificate

After

within 24 hours atter death

To the Funeral Director: , completely filled in by the f

funeral

To the Hospital or Attending Physician:

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Funeral

Director

"natural", or Items 23a or 28a-f show cdical Examiner must be notified at

72 hours after

permit. Pages 1 and 2 should be filed within 72 ho Department of health and Mental Hygiene. Droptant: If them 27 is marked other than "naturally injury or other traumatic event, the Medical

Alth and Mental Hv

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

burial-trans use as the ō signed by the a Completed page 2 Be

Exami Physician/Medical þ

2

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

2X No

1 ☐ Yes

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 4☐Pregnant at time of death 9☐Unknown

5 ☐ Other (specify)

3 Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2

No 3

Probably 4

Unknown 24a. Was an

autopsy performed? 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Hospital: 1 Hinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

determined

29c. License number D59738

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive Rockville, MD 20850 T. Mistre 31. Date filed (Month

State Registrar Day Year) 32. Paristrar's Signature

			for State	State of Ma					nd Me	ental Hy	giene			
			Registrar	-0		Cer	tificate of I	Death			Reg. No	007	290	920
50	Physici	an	1. Decedent's Name (First, Middle, La	,					1	2. Date of Dea Month	Day	Year	3Time o	Death •
33	/Medi		Bertha Doris Jac 4a. Facility Name (If not institution, given				4b. City, Town, or	r Location of	Doath	8	28	2007 county of Death	8:32	a ^M
	Examir	ier	,	,	ioanital				Deau			cince Ge	Orgae	
	Funeral			Sex 7. Age	e (In yrs. last bir		Chever.	If Under 2		8. Date of Birt	h		place (State ontry)	or Foreign
1	Director		075-38-5083	I□M 2∏xF	62	Yrs.	Months Days	Hours	Min.	(Month, Da March	7, 19	945 Edge	efield	, SC
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	orloc	ation							
	faryla sho	ō		_									10d. Inside C	2 □ No
	the N	Director	MD Prince (Georges	Hyatts	Vil	Le 10f. Zip Code	_			10a Citiza	en of What Cou		
	3a or		5064 Kennilworth	Azzonijo			2078	Ω1			US		iuy:	
	death	Funeral	11. Marital Status	12. Was Decedent B	ever in U.S.	13. W	/as Decedent of H Yes, specify Cuba		in? (Spec	ify Yes or No		1. Race - Americ		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Ď	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:	lo		Yes, specify Cuba ☐ Yes 2 No	an, Mexican, Specify:	Puerto R	ican, etc.)		Black, White, Specify: B1		
Š	72 ho natur lical l	Completed	15. Decedent's E (Specify only highest gr	ducation	16a.	Decede	ent's Usual Occup	ation	of working		16b. Kind	d of Business/In	dustry	
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2	led w lygier her th	S	High School/12		D	ayc	are Prov				Priv			
anc	n = 0 9	Be	17. Father's Name (First, Middle, Last	•						First, Middle,				
Ž	should be tand Mental I s marked or umatic eve	으	Robert Hugh Byro		19h	Mailing	Address (Street			hel Si		_	Cadal	
ĕ S	nd 2 sulth ar		Terry Jackson/Da	,			Kennilwo:						781	
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev	1	1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		1		_Cemeter;	1	ent 4	2007	T.ar	ndover,	MD	
ati	rmit. poartn porta y Inju		21. Signature of Funeral Service Lice	nsee	Hath		Name and Address					orgia A		V.W.
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ŗ.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do n e.	ot ente	r the mode of dyin	g, such as c	ardiac or	respiratory ar	rest,		Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	_a. MK	TA SIX	MC	COL	LIM	U	ANCE	6		Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	of):								
		-	Sequentially list conditions,	b to for as a	rechisequence o	ži:								
	uted d ansit	mìn	dury, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,								
Ó	exec an and rial-tra	Examiner	resulting in death) Last	Due to (or as a	consequence o	of):								
58760	cate be executed physician and the burial-transit	edical		d										
_	ertifica ing ph east	Med	IF FEMALE:											
ROX	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth	2 Fetal death		Ectopic pregnancy				23	d. Date of delive	•	Year
O	he de the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant at 9∐Unknown	time of death	5 🗆	Other (specify)					World	Day '	Teal
٦.	that the ed by detac		Part II. Other significant conditions	contributing to death bu	t not resulting in	the und	derlying cause give	en in Part I.		23e. Did to	bacco use	contribute to t	ne cause of d	leath?
Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	d by								1 🗆 Y	es 2	No 3□Prob	ably 4 🔲	Jnknown
ပြ	s beel	Completed								24a. Was a	an	24b. Were auto	nsy findings	available
ř	The la te has	ошр								autop perfor	sy med2	prior to co	mpletion of c	ause of
<u> </u>	60 17	d)	25. Was case referred to medical					26. Place o	of Death (1□ Yes Check only o	2/2 No ne)	1 ☐ Yes	2.2 No	
٥ ٥	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier	nt 2/ER/Out	patient	3 DOA Othe	or.				☐Other (Specif	y)	
	Ing P		27. Manner of Death 1.☑Natural 5 □ Pending	28a. Date of Injur (Month, Day		ime of ijury	28c. Injury Work	/ at c?	28	d. Describe h	ow injury o	occurred		
<u>s</u>	ttend death. stor: /	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No						
UNISION	after of Direct in by	ertification:	4 ☐ Homicide determined	28e. Place of inju- building, etc	(Specify)	m, stree	et, ractory, office		28	f. Location (S City or Tow	treet and I n, State)	Number or Rura	l Route Num	ber,
	spita nours neral	O	29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge,	, death	occurred at the tim	ne, date and	place, an	nd due to the	cause(s) ar	nd manner as s	tated.	
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	examination and	d/or inve	estigation, in my op	pinion, death	occurred	d at the time,	date and p	lace, and due to	the cause(s	;)
	To the Comp	ž	29b. Signature and title of contifier	1.	0		29c. License	number		2	29d. Date	signed (Month,	Day, Year)	
•	6) XUC	, //(10		01	0/7/	5		8.3	30.07		
			30. Name and address of person who	RAMAN MY	2	Type, P	1000 A	CIRE	NBC	MA SI	740	U#3		
197	Sta	-	31. Date filed (Mon S Pap Year) 4	7007 32. Sistra	r's Signature	A	B 0	_#_T/T_\/	1	a vo.	7.0			
	Registr	ar		Acel	w w	MI								

State of Manyland / Department of Health and Mental Hygiene

						aryiari				Death	F	leg. No.	17	29	921
	Physici	an	Decedent's Name (First, Midd		.01.0.5	0-					2. Dete of Dea Month	Day	Year		of Death
~	/Medi	cal	Thomas		nes	D	•			4b. City, Town, or L		1ber 01, 20		2:2	0 P.M.
1	Examir	ner	4a Facility Name (If not institution	in, give street In Mano		. Home	2			Cumbe		vo. obanty	Mary	/land	
	- Francisco		5. Social Security Number	6. Sex			last birthday)		r 1 Year	If Under 24 Hrs.		1			e or Foreign
	Funeral Director		214-62-2610 Usual Residence of Decedent	15 M		56	Yrs.	Months	Days	Hours Min.	February	19, 1951	Coun	Maryla	nd
	aryland show dat	_	10a. State 10b. Count	•		10c. Cit	y, Town or Loc	ation			-		1		City Limits es 2 □ No
	8a-f	Sct	Maryland	Allegany				404.7	0-4-	Midland		Iog. Citizen of V	What Cour		
	h with t	al Dir	10e. Street and Number	13 Broad	Street			101. 21	p Code	21542		rog. Ollizeri or ¥	U.S.	-	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or Items 23a or 28a-f show important: if item 27 is marked other than "naturel", or Items 23a or 28a-f show hipty or other traumatic evant, the Madical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 M Ma 3 □ Widowed 4 □ Divorce	rried 1	as Decedent med Forces? Yes 2 Yes, Give ear or Dates:			Vas Dece Yes, spe ☐ Yes	1 .	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- Pican, etc.)	14. Rac Blac Specify	e - Americ k, White,		
Maryland 21215-0020	within 72 ho ane. than "natur ne Medical	mpieted	(Specify only high Elementary/Secondary (0-12)		pleted)	5+)	16a. Deced (Give I life. D	ent's Usi kind of w OO NOT	ial Occup ork done use retire		king	16b. Kind of Bu		dustry	
d 2	filled Hygi sther	ပိ	17. Father's Name (First, Middle	e, Last)						Driver 18. Mother's Nan	ne (First, Middle,	Maiden Surnam	Truck	ang	
lan	id be ental ked c	To Be	т	homas Ju	ınior Jam	es. Sr.					Ellen J	ean Fazeni	baker		
lary	2 should be filed with and Mental Hygiene. is marked other than aumatic evant, the M	-	19a. Informant's Name/Relation			,	19b. Mailin	g Addres		and Number or Ru					
	Health Health tem 27 i		Paula Ann 20a. Method of Disposition	James - V	Wife	20h F	Place of Dispos	sition /Na		Broad Stree	et, Midland,	Maryland 20c. Location -			
Baltimore,	Pages nent of H ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Remov	al from State	200.1	Place of Disposemetery, crem				September				
altir	permit. Page Department of Important: If eny Injury or once.	-	21. Signature of Funeral Service				Cumber			ess of Facility Eichhorn-M	05, 2007		erland,	Iviai y	ianu
ä	Depa Impo eny la		DI CM	M					8 F2	st Main Stre	et Lonacon	ino Marvl		1539	
			23a. Part 1. Enter the disease, or shock for heart failure. Lis	or complication st only one cau	ns that caused use on each li	d the deat ne.	h. Do not ente	er the ma	de of dyi	ng, such as cardiac	or respiratory ar	rest,	į.	Approxir Interval I Onset ar	nate Between nd Death
1	Physician /Medical		Immediate Cause (Final disease or condition		(-	ul	meno	- (¢ 11-1	Jolin				m	eduti
	Examiner	_	resulting in death)	a		Due to (c	or as a consequ	1					-		
	uted d ansit	mine	O and the Health and Allinea	b		Due to (c	r as a consequ	uence of					- 1		
o,	e exection and and and and and	Еха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			0) 0) 90 0	as a consequ	uonoc on							
68760,	icate be executed physician and s the buriel-transit	dica	that initiated events resulting in death) Last	c		Due to (o	r as a consequ	uence of)	:				1		
	certificanding pluse as 1	n/Me		d									- 1		
Box	death cer attendin d for use	icial	Part II. Other significant condit	ions contribut	ing to death b	ut not res	ulting in the un	nderlying	cause di	ven in Part I.	23b. Did t	obacco use co	ntribute te	o the cau	se of death?
P.0	The law requires that the death certificate be executed ete hes been signed by the attending physician and page 2 should be detached for use as the buriel-transit	Physician/Medical Examiner		ment				,				fers 2□No			l □ Unknown
ds,	signe Id be c	d by	0	7-	(24a. Was	an autopsy	24b. W	ere autop	sy findings
of Vital Records,	w require s been si	Completed	COPD								perfo	med?	co	ailable pri mpletion death?	
æ	The law te hes page 2	E									101	as 25140	1	Vue 1	2⊒No
ita	icien: The certificete rector, paç	Bec	25. Was case referred to medic examiner?	al			-				ath (Check only o	ne)			money-
>	Physicien: r this certific rral director,	2	1 Yes 2 No	Hospit	al: 1 🗆 Inpatio	ent 2	ER/Outpatien	t 3□ C	UA I		lome 5□ Resid			<i>(y)</i>	
o uc	Sing Pl	tion:	27. Manner of Death 1 □ Natural 5 □ Pend		a. Dete of Inju (Month, Da	iry ly Year)	28b. Time of Injury	М	28c. Inju Wo 1 □	ryat rk?]Yes 2⊡No	28d. Describe h	ow injury occur	red		
Division	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificete hy completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could	d a at ha	e. Place of In building, et	jury - At h	ome, farm, stre	eet, facto	ry, office		28f. Location (S City or Tox	Street and Numb m, State)	er or Rur	al Route N	lumber,
	Hospita 24 hour Funera itely fille	edicai ((Check only one)	il Examiner: C	To the best on the basis o	f examina	wledge death tion and/or inv	restigatio	tat the ti n, in my o	m. date and dace opinion, death occu	and due to the erred at the time,	date and place,	anner as s and due t	tated. o the caus	se(s)
	o the o the omple	Mec	29b. Signature and title of certif		and manner st			2:	9c. Licen	se number		29d. Date signe	d (Month,	Day, Yea	ir)
	F≯Fö			leni	20.				00	10/7565		fept.	4. >	2007	
		_	30. Name and address of perso					Print)	1	2017565 2021e	(7)	215	02		
	CH	2	31. Date filed (Month Pay Yea	(1)	32. Registi	rar's Signa	t' H	7			-10	, , ,			
	518	ate	SEP	@ 2007	la la la la la la la la la la la la la l		de	60							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year hunia 200 /Medical atembe 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NO KING Date of Birth (Month, Day, last birthday Sex 14⊡ M 2⊡1€ Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Yrs. 82 5318 Director OCT, 1, 1934 S. KOREA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD MONTGOMERY Director SILVER SPRING 1 XYes 2 No 10f. Zip Code 20905 10e. Street and Number 10g. Citizen of What Country? 87 CARONA CT. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: ASIAN 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOST HOSPITALITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAN K KIM OK JOO CHANG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 CARONA CT, SILVER SPRING MD 20905 JUNG AE KIM / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State 5 ☐ Other (Specify) METROPOLITAN SEPT, 4,07 ALEXANDRIA VA 4 ☐ Donation 21. Signature of Fungral Service 22. Name and Address of FacilityCHARLES HINDS FUNERAL SERV 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the disea and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Du & (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an e 2 certificate 1□ Yes 2 No to the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 | Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and alle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Stephens, ma Johns Hopkins Hosp, tol Loon Wolfe Steet 31. Date filed (Month, Day, Year) 32. Registrar's Sign State SEP 0 4 2007 Registrar

Physician /Medical **Examiner**

death with the Maryland

1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

M.D

D0014905

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE AVE. # 111. COLL

7307 MOON 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State SEP 0 4 2007 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical



and manner stated.

7-06619		Please Type or Print in Black Indelible		_	ible.
mber Lynn Ka		State S. Maryana spananon		Hygiene	0007 000
		Registrar	or Death	Reg	9 No. 2017 299
Physici fedical Exami		1. Decedent's Name (First, Middle,Last) Amber Lynn Kashner		Month August 26,	Day Year 1144 hrs
*		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death
		3027 Charles Street	Fallston, Md		Harford
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		231-31-1182 _{1 M 2xF} 28	Yrs. Months Days Hours	Min. July 1	16, 1979 Country) VA.
market and the selection of the selectio	e 10 e/-	Usual Residence of Decedent			10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Lo			1 Yes 2 No
Aaryland 28a-f show 1 at once,	ţ	VA Fairfax Alexands	10f. Zip Code	140	g. Citizen of What Country?
Baltimore, MD 21215-0036 permit Pages I and 2 should-be filed within 72 hours after death with the Maryland Department of Health and Mahral Hygiene Department of Health and Mahral Hygiene other than "natural", or items 23a or 28a-f sho Important! If them 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmitie event, the Medical Examiner must be notified at once.	Director	6402 Prospect Terrace	22310	10	USA
vith th s 23a e notif			Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian, Black,
eath v item	Funeral		If Yes, specify Cuban, Mexican, Pu		White, etc.
ifter d Il", or	by Fu	3 Widowed 4 Divorced If Yes, Give Year ar Detection of De	Yes 2 X No specify:		_{Specify:} White
ours		durin	dent's Usual Occupation (Give kind g most of working life. DO NOT use		16b. Kind of Business/Industry
16 n 72 h an "n ical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	inistrative Assi		National Guard Bureau
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	omp	17. Father's Name (First, Middle, Last)		ame (First, Middle, M	
15- filed al Hyg ed ott	Be C	Ronald Marshall Glover		lene Ann F	
212 212 213 214 215 215 215 215 215 215 215 215 215 215	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Ma			ber, City or Town, State, Zip Code)
MD id 2 sho lith and m 27 is)2 Prospect Terra	ace, Alexa	andria, VA 22310
G, F I and Healt Fitem			sposition (Name of cemetery, or other place)	Date	20c. Location - City or Town, State
Pages ent of nt: I				3/31/2007	Alexandria, VA
Baltimore, permit: Pages I an Department of Hea Important: If Ite	•	21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility	Everly Whe	atley Funeral Home
© ≅å≛ī		120hol C. Cyn 1136			Alexandria, VA
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	ter the mode of dying, such as cardi	ac or respiratory arre	Between Onset and
kaminer		Immediate Cause (Final disease or condition resulting in death)			Death
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	115		V5.11
	Examiner	Cause. Enter Underlying Cause (Disease or highly trad initiated avents resulting in death). Last Due to (or as a consequence of):			·
executed ian and ial - transit		events resulting in death) Last Due to (or as a consequence or): d.			
e executed sian and ial - trans	lical	UNPENDED AMENDED			
Box 68760, s death certificate be the attending physicied for use as the buri	cian/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
687 Sertifi	jan/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 1 Pregnant at time of death	Fetal death 3 Ectopic pr	egnancy	Month Day Year
Sox death e	Physic	1 Yes 2 No 9 V Unknown g Unknown	Other (Specify)		Ť.
that the denet by the detached f		Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
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ALR. T. T. Stor, p. stor, p.	ادہ ا	25. Was case referred to medical	26.Place of Death (Ch	eck only one)	
of Vital Records, P.O. ng Physician; The law requires that the this certificate has been signed by meral director, page 2 should be detaed	Ö.	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpat	tient 3 DOA Other N	ursing Home 5	Residence 6 Other: Scene
n of \ding Phy. After tf	<u> </u>	27. Manner of Death 28a. Date of Injury 28b. Time 1 Natural 5 Pending FOUND: Day, Year) FOUND		Imotorcycle r	now injury occurred rider in acident
Division tal or Attendii rs after death. al Director; ✓ led in by the fu	Certification	2 Accident Investigation Aug 26, 2007 1133 hrs	5 Tes 2 V No		
Divisi pital or Ati ours after d neral Direct filled in by	≌	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	or Town, S	Street and Number or Rural Route Number, City tate)
Divisior ospital or Attend hours after death meral Director; y filled in by the		4 Homicide determined (Specify) adjacent to road		1	Stréet, Fallston, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deached for use as the built	ical	(Check only Certifying Physician: To the best of my knowledge, death of one) Wedical Examiner:On the basis of examination and/or invest			
To 1 With To 1	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	-	()/ a las Do MANO	O.C.M.E.		August 27, 2007
		30. Note and 1755 of person who completed caus 1755 of (Item 23a)			
(5)			enn Street, Baltimore, MD	21201	
5	tate	31. Date filed (Month, Day, Year) SEP 0 4 2007 SEP 0 4 2007	-		
Regis		SEP 0 4 2007 Fac M. Bould			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Lois Gertrude Kramer Sept 2007 /Medical 02 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 920 Burning Tree Ct Westminster Carroll If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Director 545-40-9305 Dec 25 1929 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show the Medical Examiner must be notified at MD Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 920 Burning Tree Ct 21158 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ty Yes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Johns Hopkins than Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. em 27 is marked other than <u>Bookkeeper</u> University 17. Father's Name (First, Middle, Last) Be (William Henry Kauffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stre Diane Kern/daughter 920 Burning permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Crematic 4 □ Donation 5 □ Other (Specify) 2. Name and Add Pritts I 412 Wash 23a. Fart1 Furr the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one in use on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnar 4☐Pregnant at time of death 5 Other (specify) 9□Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

17. Father's Name (First, Mildule, Last	,		16. Mother's Na	ime (<i>First, Miadie, Maid</i>	en Surname)		
William Henry Ka	uffman	Mary E	Mary Elizabeth Sleichber				
19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address	(Street and Number or F	Rural Route Number, Cit	v or Town, State, Zip Co	ode)	
Diane Kern/daugh		920 Burn	ing Tree Ct				
20a. Method of Disposition 1 Burial Cremation 3	Inemoval from State	Place of Disposition (Name temperatury or o		4/200/	Location - City or Town		
4 □ Donation 5 □ Other (Special		rroll Crema			ampstead, M	1D	
21. Signature of uneral Service Vice	nsee	Pritt All W	d Address of Facility S Funeral Ho ashington Ro	ome and Cha	pel, P.A.	21157	
23a. Fart1 Eur the disease, or com	plications that caused the deat	h. Do not enter the mod	of dying, such as cardia	ac or respiratory arrest,	A	oproximate	
shock, or heart failure. List only Immediate Cause (Final	one rouse on each line.	A.			ln O	terval Between nset and Death	
disease or condition resulting in death)	a Cancel	of unit	un ru	ne	1 2	MONER	
resulting in deatily	Due to (or as a conseq	uence of);	10	8		3	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):					
that initiated events	C						
resulting in death) Last	Due to (or as a conseq	uence of):					
	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic pro			23d. Date of delivery Month Da	y Year	
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying ca	use given in Part I.	23e. Did tobacc	o use contribute to the o		
				24a. Was an autopsy	24b. Were autopsy prior to compl	findings available etion of cause of	
				performed¹ 1 Yes 2 1		No	
25. Was case referred to medical			26. Place of De	eath (Check only one)			
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □ DO		Home 5 ☐ Residence	6 Shehar (Gasaifu)	Saughter's	
27, Manner of Death	28a. Date of Injury		Bc. Injury at Work?	28d. Describe how in	iuny occurred	Licise	
1 atural 5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No	Loc. Describe now in	see Beesings now injury occurred		
3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specifi	office	28f. Location (Street and Number or Rural Route N City or Town, State)				
(Uneck only 21 Medical Exal	nysician: To the best of my kno niner: On the basis of examina	wledge, death occurred tion and/or investigation,	at the time, date and place in my opinion, death occ	ce, and due to the cause	e(s) and manner as state	ed. e cause(s)	
one,	and manner stated.						
29b. Signature and title of certifier	Λ	29c	License number	29d. I	Date signed (Month, Day	v, Year)	
Milyta	Ree my	16 0	0064547		9/4/12		
30. Name and address of person wing	completed cause of death (Item	23a) (Type, Print)	Carter	Stronti	esti-1 iuste	C HIJ JUST	
31. Date filed (Month, Day, Year)	32. Regiotrar's Signa	ture	JEANUE	- i ce i ce		1, mail 21	
SÉP 0 4	2007 Seem	It spark					

29925

5:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Wyoming

Year

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Invertal director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, Be Certification: To

Medical

WJL 10 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend ite I per doc g8/1 9-21-07 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Douglas Edward Keller Day Month Year **Physician EDWARD** KELLGR SEPTEMBER 2 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 7 / 23 / 1960 Birthplace (State or Foreign Country)
 WV 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 □ F Yrs 47 Director 233-04-2949 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at XYes 2 □ No Director WV Preston Terra Alta 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 307 Brandonville Street 26764 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes ZYNO If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 Is marked other than "n. Electric Elementary/Secondary (0-12) College (1-4or 5+) Electrician 12 Power 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patty Sue Hull Joseph W. Keller Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2676419a. Informant's Name/Relationship (Type. Print) Health a Jesse D. Keller/Son 307 Brandonville Street, Terra Alta, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Iter
any Injury or ott 9/7/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Terra Alta Cemetery Terra Alta, WV 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice ^{22. Name and Address of Facility}
Arthur H. Wright Funeral Home
105 Highland Ave., Terra Alta Mother Amo1035 26764 WV 11-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RIGHT HEART FAILURE Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4 MYS LEFT HEXRT FAILURG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine g physician and as the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CONGENITAL AORTIC STENOSIS, HEPATITISC, HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 10 24a. Was an page 2 autopsy perform 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. To the Hospital or Attending Physician: Director: filled in by within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACHIN SHRIDHARANI 600 NORTH WOLFE Year)

MA

and manner stated

STREET BALTIMORE, MARYLAND 21287 32. Registrar's Signature

5

29a. Certifier

29b. Signature an title of certifier

Medical

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

SEPTEMBER 2 2007

Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Harland B. Kelley 6:18P M August 29 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fahrney-Keedy Memorial Home Washington Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. (Month, Day, Year) December 21, 1932 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland 74 217-28-9530 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Md Washington Hagerstown 1 XYes 2 No Item 27 is marked other than "natural", or Items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 128 Sunflower Drive USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Columbia Gas 12 manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William C. Kelley Beulah E. Shaffer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel M. Martin/ wife 128 Sunflower Drive Hagerstown, MD. 21740 Method of Disposition

| Disposition | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Community | Com 20c. Location - City or Town, State 20a. Method of Disposition Sept. 1,2007 Uniontown, PA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lochstampfor Funeral Home Inc. 48 South Church St. Waynesboro, PA. 17268 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Chiter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-trar signed by the attending physician I be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown ner significant conditions contributing to death but not resulting in the under ause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 menknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♠ No this certificate has page 2 autopsy performed funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death

| Manner of Death
| Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WH-5

State Registrar Date filed (Month. Day.

State of Maryland / Department of Health and Mental Hygiene 29928 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year September 2, 2007 7:00 Jeannette Levering Lieske /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Manor Healthcare Center Cecil Rising Sun 8. Date of Birth (Month, Day, Year)
Dec. 18, 1919 If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Months Director 221-14-3491 87 Delaware Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 755 Barnes Corner Road 21911 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Completed by 3 X Widowed 4 □ Divorced White "naturei" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) 11 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Hauth and Mental Hy Important: If Item 27 ie marked othwary injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be Horace Levering Mary A. Greer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Elkton Blvd. Elkton, MD 21921 John F. Reynolds/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-5-2007 Rising Sun, Maryland Brookview Cemetery 22. Name and Address of Facility
R. T. Foard Funeral Home, P.A.
111 S. Queen Street, Rising Sun, MD 21911 21. Signature of Funeral Service Licensee schand Part 1. Enter the disease, or complications hat cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (o physician Box 68760 Physician/Medical the for use as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal deal

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Dtinknown Be Completed 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 Yes 1 TYes 25. Was case referre to medical 26. Place of Death (Check only one, examiner? Hospital: 1 | Inpatient Other: Certification: To 1 🗌 Yes 2 No 4 Jursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) r of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 28b. Time of 1 Natural 5 Pending i Director: A 1 ☐ Yes 2 ☐ No death 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a Medical 29a. Certifie f Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 0.4 2007 Registrar

			1 - For State Registrar	State of I	Marylan		artment of H				iene 2	007	29	929
	Dhysisi		1. Decedent's Name (First, Middle	e, Last)						Date of Death Month		Year	3. Time o	Death
	Physici /Medio		Howard G. Lloy	d, Jr.						eptemb			7:14	A M
	Examir	er	4a. Fecility Name (If not institution				4b. City, Town, or	Location of	of Death		4c. Cou	nty of Death		
			277-A Jackson				Perr	yvi11				Ceci1		
П	Funeral Director		5. Social Security Number 218-38-3432	6. Sex 7. 1 X M 2 ☐ F	Age (In yrs. I	ast birtnday) 5 Yrs.	Months Days	Hours	Min	Date of Birth (Month, Day, pt. 16	Year)	9. Birth	place (State	o <i>r Foreign</i> I
			Usuel Residence of Decedent						56	рг. 10	, 154	I rie	ryland	
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
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	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori n, Mexican	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)		Race - Amer Black, White		
36	rs att	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 【XDivorced	ied 1 ☐ Yes 2 [If Yes, Give Year or Date	X No		1 ☐ Yes 2 🔀 No	Specify:			Spe	cify:	T.T	
Ş	filed within 72 hours after death with the Maryland Hygiene. Sther then "naturel", or items 23a or 28a-f ehow ent, the Madical Examiner must be notified at	ed	15. Decedent		5.	16a, Dece	dent's Usual Occupa	ation			I6h Kind o	f Business/li	White	
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힏	e file al Hy vent,	Bec	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (Fi	rst, Middle, M				
<u>a</u>	Ments Ments arked	ToE	Howard G. Lloy	d, Sr.				E 1	louise	U. Joi	nes			
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentel Hygiene. Item 27 ie marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examiner hand be notified at		19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a	and Numbe	er or Rural Ro	oute Number,	City or To	wn, State, Zi	ip Code)	
	and lealth m 27		Sandy Jackson/	Daughter	1		Singerly							
0	Pages 1 nent of H int: if ite iry or otl		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from Sta	ite 20b. Pi	lace of Dispo emetery, crei	sition (Name of natory or other place	θ)	Date	2	20c. Locatio	on - City or 1	own, State	
Baltimore,	tmen tent:		4 □ Donation 5 □ Other (S	Decify)			emetery		9-7-200	07 (Chesa	peake	City,	MD
Ba	permit. Pages 1 an Department of Heal Importent: if item 2 eny injury or other once.		21. Signature of Funeral Service	Licentee			Name and Addres T. Foar			Home. 1	P.A.			
	402 V G		222 April Sotor the displace or	complications that saw	and the death		18 George	Stre	et. Cl	iesabea	ake C	ity, N	ID 2191	.5
			23a art1. Enter the disease, or shock, or hear failure. List	only one gause on each	n line.	. Do not ent	er the mode of dying	g, such as	cardiac or res	spiratory arre	st,		Approximation Interval Bet Onset and	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a Sle		SNA	a						244	-5
П	Examiner			Due to (or	as a consequ	uerice of):	. 41. 10						-	
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	uted	Examiner	Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	6 00	ilor	wie	Lynn	last					1/2.	120
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8760,	cate be executed physicien and the burial-transit	dical		Ja Pul	1001	200	y by	bez	ten	Sion	\wedge			
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Вох	death certific e attending p id tor use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth			Ectopic pregnancy					Date of deli-	,	
0.	at the death by the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant 9☐Unknowr	at time of de		Other (specify)					Month	Day	Year
<u>Ч</u>	The law requires that the site has been signed by the bage 2 should be detache	Phy								00- 01444				
က်	ires tha signed I I be det	by	Part II. Other significant condition	ons contributing to death	On the contract	iiting in the u	nderlying cause give	en in Parti.		1 ☐ Ye		_	the cause of a	
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ş	hes be 2 s	mpl								24a. Was an autopsy perform	,	prior to d	opsy findings ompletion of c	available ause of
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₹	or Attending Physician: ufler death. Director: After this certific in by the funeral director.	o Be	25. Was case referred to medical examiner?	Hospital:			t 3 DOA Othe	AC.	1	heck only one				
Division of	Physical distriction	- 1	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 L Inpa		ER/Outpatier 28b. Time of	1 3 DOX	4 140		5 Resider		Other (Spec	rfy)	
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2	or Atten after deat Director: in by the	Hica	3 ☐ Suicide 6 ☐ Could n	not be 28e. Place of	Injury - At ho	me, farm, str	eet, factory, office			Location (Str.	eet and Nu	mber or Rui	ral Route Nun	iber.
á		Certification	4 Homicide	building,	etc. (Specify	')				City or Town,	, State)			
	e Hospitai 24 hours a Eunerai letely fiiled		29a. Certifier 1 Certifyin	g Physician: To the be	st of my know	wledge, death	occurred at the tim	e, date an	d place, and	due to the ca	use(s) and	manner as	stated.	
	To the Hosi within 24 ho To the Func completely f	edical	one)	Examiner: On the basis and manner	s of examinat	ion and/or in	vestigation, in my op	inion, deal	th occurred a	t the time, da	te and plac	e, and due	to the cause(s	5)
	To the within 2 To the complet	×	29b. Signature and title of certifier	000			29c. License						, Day, Year)	
,			Pyone 1116	2 NNIT	•		1944	716		5	epte	nibe	r2,3	L007
	8		30. Name and address of person	who completed cause of	of death (Item	23а) (Туре,	Print)						- mar fall of the or	
			Jose Wa,	111 W. H	Noi	5+	Elkton	W.	VD >	197	1			
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signat	K do	arte							
	riegisti	en i	SEP 0.4	7001	5000		2 16							

State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 29930 1- State Amend #8 Per FH G872 10/19/87 tillcate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Month Day
August 31 2007 **Physician** Andrew John Lewis 9:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Charlotte Hall St. Mary's Charlotte Hall Veterans Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 1911 5. Social Security Number 9. Birthplace (State or Foreign Country)

Towa 6 Sex 7. Age (In yrs. last birthday) **Funeral** †□M 2□F Yrs. 95 498-05-2310 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28e-f show Charlotte Hall Maryland St. Mary's 1 ☐Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be r United States 20622 29449 Charlotte Hall Road Peges 1 end 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene. Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 □ X es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "naturej" al Hygiene. d other then "nature" event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) US Government storekeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tilley Peterson Andrew John Lewis ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7000 Copper Lane LaPlata MD 20646 Andrew Lewis, III- son Heelth 20b. Place of Disposition (Name of cemetery, crematory or other place Sept. 5 2007 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny injury or of 900. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery Cheltenham Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** STAG ARDIAC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or se a consequence of): physiclan and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ VLMONARY 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cartificate has birector, pega 2 s autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funarsi I McCortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056752 LN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29440 CHAPLOTTE HALLRY CHARLOTTE HALL MO 26/22 MAZNIN ESCHANI MO 32. Registras Signature 31. Date filed (Month, Day, Year) SEP State 4 2007 Registrar

			For State Registrar	State of Maryla		artment of H			2007	29931
3	Physici	& ,	1. Decedent's Name (First, Middle, I					2. Date of Death Month	2 ^{Day} 200 ^{Year}	3. Time of Death
	/Medic		Esther M.	Major		4h Cih. Tourn as	Legation of Dooth	August 2	4c. County of Dea	3:34 AM
	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, or	_			
	Funeral Director		Prince George's 5. Social Security Number 155-18-6963		rs. last birthday)	Cheves If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y Jan 14,	Prince G	thplace (State or Foreign outly)
i i	p .		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	Aaryla Fahov ed at	ō	District of Col		Washin					1.☐Yes 2 ☐ No
	28a-	rect	10e. Street and Number	L CHILD AL CO	710011211	10f. Zip Code		10g	. Citizen of What C	ountry?
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36	toges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Hem 27 is marked other then "natural", or Itame 23s or 28s-f show or other traumatic event, the Madical Examination and Lea willied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ¬YNO If Yes, Give A Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	opcony.	_{te, etc.} frican
9	2 hou atura cal E	ted	.15. Decedent's	Education	16a. Dece	dent's Usual Occupa	ation	16	ib. Kind of Business	merican VIndustry
21215-0036	ithin 7.	Completed	(Specify only highest s Elementary/Secondary (0-12)	, College (1-4or 5+)	life.	DO NOT use retired,) -	ng	Colf Emp	l arra d
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and	d be f ental h ked of	To Be	Owen D. Mike					Jones	,	
Maryland	shou and M mar	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a			City or Town, State,	Zip Code)
	and 2 ealth a m 27 i		Thomas Major - S			Robert Bo				
Baltimore,	iges 1 nt of H if Iter or oth	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Hemoval from State		osition (Name of matory or other place	!		c. Location - City or	
語	t. Partment		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Furreral Service Exi	n	incoln l	Mem. Cemet 2. Name and Addres	ery Sept	. 8. 2007	Suitla	nd MD
Ba	Depa Impo any in		1. Daniel	to most		001 Bennir				
	Physician		23a. Parki, Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that caused the dealy one cause on each line. Sepsis						Approximate Interval Between Onset and Death 2 weeks
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
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	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Gangrene of the foot						-	.2 weeks
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8760,	cate by physic the bu	dlca		d						
P.O. Box 6	that the death certificate be executed the by the attending physicien and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑tNo 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
	es that the igned by th be detache	by Ph	Part II, Other significant condition	s contributing to death but not	resulting in the t	underlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ords	en s		<u>Diabetes Mellit</u>	us				1 ☐ Yes	2 √ □ No 3 □ P	robably 4 Unknown
Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 €	prior to	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatie	other actions of the	25	h (Check only one)		
of	ig Phys ter this neral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year			4 Nursing no	me 5 Resident 28d. Describe how	ce 6 Other (Speringury occurred	ecity)
ion	결국조회	atlo	1 Accident 5 Pending 2 Accident investiga	tion	r) Injury		Yes 2 □ No			
Division		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical		Physician: To the best of my caminer: On the basis of exam and manner stated.						
	To the vithin To the comple	Σ	29b. Signature and title of certifier	1 menths	, _	29c. License		290	d. Date signed (Mor	oth, Day, Year)
0	(I)		PRICE	The state of the s	Nam 226) 7	D16273			5/2/	/ - /
	0		30. Name and address of person w Revathey Mokthy				MD 20785			
	Sta Regista		31. Date filed (Month, Day, Year) SEP 0 5 2007	32. Registrar's Si	gnayure operation	V C + de y				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 29932 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 1:40 P M Sept. 2007 Mary Ellen Mallon 3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Baltimore Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 217 F Director 88 Maryland 215 09 6344 May 1, 1919 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director <u>Marriottsville</u> Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code r than "natural", or Items 23a or the Medical Examiner must be 10411 Wetherburn Rd. 21163 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes ŞE No Specify: White 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Alth and Mental Hyc. 7 is mark. traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Justis Weisenborn Mary Lindner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other t Bluffton, SC 29910 Mary Jane Knight/daughter 58 Lexington Dr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If It any Injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dak Lawn Cemetery 9/6/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) M01442 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 21. Signature of Juneral Service License 4112 Old Columbia Pk. Ellicott City, MD 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE Physician DAYS /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bue to (or as a consequence of) Examine that the death certificate be executed and Due to (or as a consequence of). attending physician a for use as the burial-P.O. Box 68760. Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Yes 2 No 9 ☐ Unknown Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Stother (Specify) HOS ACE Hospital: 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 No tal death. 2 Accident Funeral Director 6 ☐ Could not be 3
☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6.336 Cedar Ly #237 4 ☐ Homicide hours aiter Nursing Hospital Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 24 and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SEPTEMBER 4,2007 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) DANIENE DOBERMAN, MD 6565 N CHARLESST, SUITE 216 BALTIMORE, MD 21204

State Registrar

31. Date filed (Month, Day, SEP 0 5 2007

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	land			10a. State	10b. County				10c. City	, Town	or Loca	ation			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other tran instruments to health and hadded Examiner must be notified at	6	ō	w l	77.										
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O Boy 68760	the death certificate be executed the attending physician and school for use as the burial-transit	ģ	ysician/Medical	IF FEMALE:		00-	If you see	tooms	f nross-	201					
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ation of Death 4c. County of Death Wiconico Jnder 24 H Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Min 02/16/1922 Maryland 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? USA nic Origin? (Specify Yes or No-lexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry g most of working <u>Own Home</u> Mother's Name (First, Middle, Maiden Surname) ırgaret Lydia Mandayohl Number or Rural Route Number, City or Town, State, Zip Code) ., Salisbury, MD 21801 20c. Location - City or Town, State 09/08/2007 Baltimore, Maryland Facility al Home et Ave., Princess Anne, ich as cardiac or respiratory arrest, 23d. Date of delivery Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24a Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) + 5 ☐ Residence Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

s been signed by should be deta Division or Vital Records, P To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.8

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier deigens the 29c. License number

29d. Date signed (Month, Day, Year) 09-02-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIOM. BELLOSO, M.D.: 530Z CHINABERRY DR., SALISBURY, M.D. 21801 31. Date filed (Month, Day, Year)

State Registrar

EB

Medical

SEP 0 5 2007

timor

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mamber 3 Mayfield Hermon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Hospital Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 587-07-6461 Director April 10 1946 Mississippi Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Prince George's 1 N Yes 2 No Bowie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16525 Governor Bridge Road 20716 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Army 1 ☐ Yes 2 ☑ No Black Specify Be Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental I Pages 1 and 2 should be Henry Boyd Mayfield Lucille Everette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16527 Governer Bridge Road Bowie, Maryland 20716 Nichole Lindsey/Daughter Injury or other Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 9/8/2007 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery Waynesboro, Mississippi 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover RoadLandover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER **Physician** 7ETA 514 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of): attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 58187 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) use of death (Item 23a) (Type, Print)
1525 Green way Center Drive, Suito 113, Green belt, m) Registrar

DHMH 17 Rev 1/2001

Funeral

Director

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Items

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Pages 1 and 2 should be filed with the property of Health and Mental Hygien tant: If Item 27 Is marked other the njury or other traumatic event, the

Department of Health Important: If Item 27 any injury or other troops

Medical

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran ours after death.

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filled in by the fr 24 hours a within 24 ho To the Fun completely

Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

15H-15 State

SEP 0

GHA ZALA

1190 MI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

ROAD

HAGEMTOWN

		1 - For Amend Item 2		f Marylan	02/02/d	artment of F	lealth a Death			007 29937		
Physic /Medi		Decedent's Name (First, Middle, Li Ruth Irene MACTA	,					2. Date of Month Septe	ember 4,			
Exami	ner	4a. Facility Name (If not institution, git 1428 Salem Avenu	ie	mber)			agerst	own		shington		
Funeral Director		219-20-2188	Sex 1 □ M 2 🖾 F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month	Birth Day, Year) 9, 1926	9. Birthplace (State or Foreign Country) Hagerstown, Md.		
e Marylend 3a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Wash	ington	10c. Cit	y, Town or Lo	erstown		,		10d. Inside City Limits 1 Q Yes 2 ☐ No		
with th	i Dire	10e. Street and Number 1428 Salem Avent	ıe			10f. Zip Code	21740			10g. Citizen of What Country? USA		
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or lieme 23a or 28a-f show other traumatic event, the Madical Engineer mail the mutillied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced		2 Mo ve		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No		in? (Specify Yes o , Puerto Rican, etc.		ace - American Indian, ack, White, etc. white		
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and 2 should be alth and M n 27 is mark		19a. Informant's Name/Relationship Connie Purdham -			1428	Salem Av	7e., H	or Rural Route No agerstown		n, State, Zip Code) .740		
Baltimore, permit. Pages 1 an Department of Heal Important; if Item 2 ent injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		State		sition (Name of natory or other place) on Mem.Pa		Date 9/8/07		n-City or Town, State		
Ball permit Depar Impor		21. Signature of Funeral Service Lice	MA	Jann	usel		son Bl	Lvd., Hag		Md. 21740		
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is, P.O. Box 68760, res that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes	d. 23c. If yes, ou 1 □ Live b	(or as a consequence of pregna birth 2 ☐ Fetal nant at time of drown	ncy	Ectopic pregnancy	,			Date of delivery Month Day Year		
ecords, P.O. law requires that the dest been signed by the	<u>م</u>	Part II. Other significant conditions	contributing to d	eath but not resu	ulting in the u	nderlying cause giv	en in Part I.		id tobacco use co	ntribute to the cause of death?		
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13H-5		30. Name and address of person who	md 13	424	Penn	Print)	Ave	me Had	jentone	mo 20742		
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State of Maryland / Department of Health and Mental Hygiene 0 0 7

			For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment of F tificate of	lealth ar Death	nd Mental Hy	/giene2 Reg. No.	007	29938
	Physici	an	Decedent's Name (First, Middle, La	<i>'</i>					2. Date of D Month	Day	Year	3. Time of Death 1:34 aM
All Park	/Media	cal	Wardley B. 4a. Facility Name (If not institution, given		ber)		4b. City, Town, o	r Location of I	August Death	31 4c. Cd	2007 ounty of Death	1.54 a
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	Funeral		Social Security Number 6. S	Sex 7	7. Age (In yrs.	last birthday)	if Under 1 Year Months Days	If Under 24		rth av. Year)	9. Birthp	place (State or Foreign
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	pug "	1	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					0d. inside City Limits
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	the 128a-	Director	10e. Street and Number	лиет у			10f. Zip Code	Opiling		10g. Citize	n of What Cour	ntry?
	3a or	Ö	2374 Glenmont	Circle, #1	L03			20902			Jamaica	
	death	Funeral	11. Marital Status	12. Was Deced	dent Ever in U	I.S. 13.	Was Decedent of H	lispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	0- 14	. Race - Americ Black, White,	
98	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1 ☑ Never Married 2 ☐ Married	1 ☐ Yes If Yes, Give	2k∏ No		1 ☐ Yes 2 🖾 No	Specify:		S	necify:	
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Baltimore,	it of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from S	1	cemetery, crei	natory or other pla	i			ition - City or To	
tim	it. Pa		4 ☐ Donation 5 ☐ Other (Special Service Lice		Par		morial Parl 2. Name and Addre		9/8/2007	Rocky	ville, Ma	ryland
Ba	permit. Pages 1 an Department of Heal Important: if item 2 any Injury or other		21. Signature of Purieral Service/Cice	1	N	H	ines-Rinal	di Funer	al Home, Inc		udana Mass	rr1 and 2000/
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Ž	Physician: this certific ral director.	o Be	examiner? 1 ⊠ Yes 2 No	Hospital:	patient 2 F	ER/Outpatier	nt 3 DOA Oth	oer.	sing Home 5 ☐ Res		Cother (Speci	f _V)
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	o the o the omple	Mec	29b. Signature and title of cartifier	/ /			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
	1		▶ IAA ha	W. (10		D6	2520		Aug	ust 31, 2	007
	6		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print)					
			Maria D'Arbela, M				-	pring, M	laryland 209	10		
	Sta	ate	31. Date filed (Month, Day, Year)	32. 7	gistrar's Sign	ature	1 4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Regist/AMEND#12perFHa,perMD,9/7/07,DPS,NGertificate of Death 29939 Reg. No. 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 **Physician** Ε. Randa11 September 8:15P M Marcus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 Le Havre Court Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 1964 | 196 Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Year) 11√ M 2 □ F 60 Yrs. WASHINGTON, DC Director 220-48-5009 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show at ns 23a or 28a-f sh must be notified 1X Yes 2 □ No Director MARYLAND | MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Le Havre Court 20854 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23, any Injury or other traumatic event, the Medical Examiner must by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No 1965 If Yes, Give Year or Dates:1966 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT COMMERCIAL REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IRVING HAROLD MARCUS ROSE FOX ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE S. MARCUS - WIFE 5 Le Havre Court, Potomac, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 JUDEAN MEMORIAL GDNS 09/03/2007 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ocular Melanoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death P.O. 5 Other (specify) 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2√2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autonsy performed? certificate 1 Yes 2 XNo 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation 1 X Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 □ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

10(10)

State Registrar

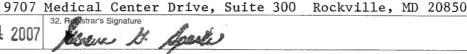
Medical

(Check only one)

29b. Signature and title of co

Manish Agrawal

31. Date filed (Month Day Year)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D62234

29d. Date signed (Month, Day, Year)

September 2, 2007

07-06893 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kimberly Ann Minnick 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Day r 4, 2007 Month **Medical Examiner** September 4, Kimberly Ann Minnick 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Garrett Garrett Memorial Hospital Oakland If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Funeral Foreign Countr Maryland Months Hours 216-06-9039 Days Apr 3, 1980 Director 27 2X F M Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c, City, Town or Location Accident MD Garrett death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21520 USA 579 Accident-Friendsville Road uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes or 屲 3 X Widowed f Yes, Give Year Specify white Divorced Yes 2 X No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit, Pages 1 and 2 should be filed within 72 l Department of Health and Montal Hygiene. MD SHA 12 Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ann Swauger Eugene Garlitz If item 27 is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 603 Blocher Rd., Frostburg, MD B 21532 Eugene & Mary Ann Garlitz/parents 20b. Place of Disposition (Name of cemetery, 20c, Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sept 8, 2007 Accident, MD Zion Lutheran Cem. Donation 5 Other Specify 22. Name and Address of Facility' 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A. Grantsville, MD 23a. Part t. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate. Due to (or as a consequence of) * 1 1 1 1 could. Enter Underlyin (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. þ Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed 24b. Were autopsy findings available 24a. Was ar autopsy

1929 hrs

Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

Hospital or Attending Physician: The law requires that the death certificate be executed Records, certificate has Division of Vital this After Director: filled in by within 24 hours after To the Funeral Dire

Be

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State

31. Date filed (Month, Day, Year)

OCME

prior to completion of cause of performed? death? ✓ Yes 2 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: Other₄ DOA Nursing Home 5 Inpatient 2 PER/Outpatient 3 Residence 6 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Pedestrian struck by auto Sep 4, 2007 1854 hrs Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 859 Accident Friendsville, Accident, MD determined (Specify) Local Street Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 5, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner

Registra DHMH 17 Rev 1/2001

OCME 2006

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

41

And Designation of the last of	n/	1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2007 299 2. Date of Death Month Day Year 1906 bro				
al Examine		Jerod Lee Minnick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Accident 859 Accident Friendsville Road Accident	September 4, 2007				
Funeral Director		216-98-5716 1 _{XM} 2 _F 25 Yrs. Months Days Hours	er 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country Maryland				
Maryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 Yes 2 XNo				
the land	Director	10e. Street and Number 579 Accident-Friendsville Road 21520	. 10g. Citizen of What Country? USA				
	d by Funeral	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 3 Widowed 4 Divorced If yes 2 X No If Yes, specify Cuban, Mexican If Yes, specif	Note: White, etc. Specify: white kind of work done 16b. Kind of Business/Industry				
iled within 72 hours afte Hygiene. I other than "natural", th Medic I Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT 12 Well Driller	Wells				
oujd be filed within 72 I Mental Hygiene. s marked other than ' it event, the Medic I	e B		r's Name (First, Middle, Maiden Surname) chaela: Smith mber or Rural Route Number, City or Town, State, Zip Code)				
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatte event, the Medical		Steven & Michaela Minnick/parents 549 Accident-Fr 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	pate 20c Location - City or Town, State apt 8, 2007 Accident, MD Newman Funeral Homes, P.A.				
ysician Medical aminer		23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,	t., Grantsville, MD 21536 cardiac of respiratory arrest, shock, or heart Between Onset and Death				
ecuted and -transit	al Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.					
requires that the death certificate be ex been signed by the attending physician nould be detached for use as the burial	hysician/	past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) g Unknown	23d. Date of delivery Month Day Year art I. 23e. Did tobacco use contribute to the cause of death?				
law requires that to the state of the state	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?				
2 2 20 1			1 Yes 2 No 1 Yes 2 No 6.Place of Death (Check only one)				
ysician: The	<u>m</u>	examiner? 1 Ves 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA Other 4	Nursing Home 5 Residence 6 Other: Scene				
itending Physician: The leath. Ior: After this certificate the funeral director, page		1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Street 4 27. Manner of Death 1 Natural 5 Pending Sep 4, 2007 1 Yes 2 Ves 2 No Street 4 28a. Date of Injury 28b. Time of Injury 1854 hrs 1 Yes 2 Ves 2 Ves 2 Ves 2 No Street 4 1 Yes 2 No Street 4 28b. Time of Injury 1854 hrs 1 Yes 2 Ves 2 Ves 2 No Street 4 27. Manner of Death 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 20b. Time of Injury 28b. Time of Injury 28b. Time of Injury 2	k? 28d. Describe how injury occurred				
spital or Attending Physician: The hours after death, neral Director: After this certificate / filled in by the funeral director, page	ertification: To Bo	1 Yes 2 No Institute 2 ER/Outpatient 3 DOA Street 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Notice 1 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc.	k? 28d. Describe how injury occurred Pedestrian struck by auto				
ospital or Attending Physician: hours after death, uneral Director: After this certi y filled in by the funeral director	Certification: 10 B	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, et (Specify) Local Street 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocard manner stated.	28d. Describe how injury occurred Pedestrian struck by auto 28f. Location (Street and Number or Rural Route Number, City or Town, State) 859 Accident Friendsville Road, Accident, MD ace, and due to the cause(s) and manner as stated. courred at the time, date and place, and due to the cause(s)				
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical Certification: 10 Bo	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, et (Specify) Local Street 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocard manner stated.	28d. Describe how injury occurred Pedestrian struck by auto 28f. Location (Street and Number or Rural Route Number, City or Town, State) 859 Accident Friendsville Road, Accident, MD ace, and due to the cause(s) and manner as stated. courred at the time, date and place, and due to the cause(s)				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 23a Pt II, 25, 27, 28 at 11, 27, 27, 28 at 11, 27, 27, 28 at 11, 27, 27, 28 at 11 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 07ea 01 ROBERT т. MCDONALD 0640 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jun 7, 1964 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1**√** M 2□ F 208-58-7754 43 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show 23a or 28a-f shoust be notified at WV Mineral Keyser Director 1 ☐ Yes ≩☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26726 175 S. Main Street USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: white þ 3 ☐ Widowed ♣☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer lumber yards permit. Pages 1 and 2 should be filed be permit. Pealth and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Agnes E. McDonald Manolis 19a. Informant's Name/Relationship (Type. Print)
Agnes Manolis 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 12 N. Main St. Apt. 508 Keyser WV 26726 mother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 9/1/2007 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name**3caApters** Pure Pal Home, PA for Fredlock Funeral Home 108 Virginia Avenue: Cumberland, MD 21502 231 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line.

Immerite Cause (Final disease or condition resulting in death)

a. Decompensated Cirrhosi's of the Approximate Interval Between Qnset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-tra Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by icate has been siç r, page 2 shouid b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate | or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗙 Yes 🚖 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year)

August, 2007

Unknown M 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 2 Natural 5 Pending investigation Subject burned hip with heat-1 ☐ Yes 2 No n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu 2 Accident 3 Suicide ing pad (extended use) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 175 S. Main Street 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home Keyser, West Virginia Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year)

State

Registrar

CUM BERLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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32.

Registrar's Signature

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Year)

31. Date filed (Month, Day,

D62177

VICTOR CRENTSIL

State

DHMH 17 Rev 1/2001

Registrar

Eric MaDonald md 7503 Surratts RD Clinton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007 29944 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Irene Kathryn 10:46P M September 3, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charles County Nursing Rehab Center La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 F 218-38-7929 Director October 10,1909 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5020 Port Tobacco Road 20662 iteme 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after of the followed the filed and Mental Hygiene.
snt: If item 27 is marked other then "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morgan L. Monroe Maggie L. Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is eny injury or other treu once. John Monroe/Nephew P.O. Box 241, La Plata,MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Old Durham Church Cem. 9/7/07 Ironsides, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01458 21. Signature of aneral Service Licensee AREHART ECHOLS" FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dehydration **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner to S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Dementia resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknowh 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of confflor 29d. Date signed (Month, Day, Year) D0057999 9/4/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrace Drive Ste 103. Walder, MD 20602 JARIWALA, MD 31. Date filed (Month, Day, Year) 32. Poistrar's Signature State Registrar SEP 0 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 20b per fh, g8/1,09/19/07dhb Reg. No. Reg. No. 2007 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Richard Donahue Powell eptember 05 2007 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 220-16-2364 Director Yrs. 84 1923 Maryland June 1, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☑Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 12 South Walnut Street Apt. 204 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Affiled Folces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: WWII 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Maintenance Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Patricia Reed (Daughter) 233 Woodpoint Ave. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any injury or o
once. 09/07/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-2007 Smithsburg Crematory (Smithsburg, Maryland 21. Sinat ensee 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 23a. Peri1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVENE COLLIS **Physician** /Medical Due to (or as a consequence of): Examiner EPSUS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed CEREBROVASULAR ACCIDENT physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, week REHAL PAIWIRE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 **K**No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifler Medical and manner stated. 29c. License number 29b. Signature and title of certifier

\$H-0+| State

31. Date filed (Month, Day, Year) SEP 0 7 2. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MT AONA ROMS

HOGENITOWN

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29946 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Phil Hileman Pensyl 29, 2007 Aug. 14:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Aug. 13, 1914 PA Director 215-44-3410 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5913 Ipswich Road 20814 U.S.A. Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Standardization Coordinator</u> U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Henry Hileman Pensyl Ruth Roxanna Campbell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie L. Pensyl / Wife 5913 Ipswich Rd Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ð Sept. 4,07 | Altoona, PA Alto Reste Park 22. Name and Address of Facility 21. Signature of Funeral Service Licens Joseph Gawler's Sons, Inc. Willow -5130 Wisconsin Ave. N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) teart menths **Physician** Failure /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No spital: 1 Anpatient 2 [28a. Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 XMatural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendi within 24 hours after death.

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melissa L. Means, MD 8600 Old George Town Road Bethesda, Md 20814

State Registrar

Medical

- 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** Richard Oscar ROHRER 4:45 a. M 4. 2007 Sept. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Julia Manor Nursing Home Hagerstown If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 90 Maryland July 20, 1917 214-09-0879 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State 77 is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Modical Examinar must be notilised at 1⊠Yes 2□No **Funeral Director** Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 USA 11 West Baltimore Street 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: white Be Completed by WW TT 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) railroad fireman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Menta Importent: If them 27 is marked any injury or other treumatic events. John Henry Rohrer Margaret Loretta Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 W. Baltimore St., Apt. 613, Hagerstown, Md. 21740 Ardis Rohrer - wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/7/2007 Cedar Lawn Mem. Park Hagerstown, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Abdominal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician mi IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to I□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ormentis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 100 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation completely filled in by the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funerel [29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060396 opai 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gerstann. 1 ANID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

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	hysicia /Medic			yllis Rep	p			2. Date of Death Month Sept. 1, 2	2007 Year	3. Time of Death 4:15рм
. Fu	xamin neral ector	er	4a. Facility Name (If not institution, give 12034 St. Par 5. Social Security Number 217-28-6637	ul Road	yrs. last birthday) Yrs.		Spring, If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	Washing 9. Birthp	plece (State or Foreign
P		tor	Usual Residence of Decedent 10a. State 10b. County MD Washin	gton 10c	City, Town or Lo			Sept 18,		Od. Inside City Limits 1 ☐ Yes 2X No
th with the	ast be not	Funeral Director	10e. Street and Number 12034 St. Paul	Road		10f. Zip Code 21722	2		Citizen of What Coun	try?
.0036 hours after dea	event, the Medical Examinat rust be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	li li	Vas Decedent of Hisp i Yes, specify Cuban,	panic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
Z1Z15-0036 d within 72 hours aff jiene.	the Medical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12) 8th grade	ucation de completed) College (1-4or 5+)	(Give l	ent's Usual Occupation of work done dur DO NOT use retired)	ring most of workin	a	Kind of Business/Inc Wing fac	*
Maryland 2 Maryland 2 d 2 should be filed th and Mental Hygic 7 is marked other	2.0	To Be C	17. Father's Name (First, Middle, Last) Robert Willia	m Swope		11	8. Mother's Name Pearl A	(First, Middle, Maide	on Surname) Arnold	
_ = = 0	other traumat		19a. Informant's Name/Relationship (7 Gene Edward Re		19b. Mailin	Address (Street and	d Number or Rural	Route Number, City	or Town, State, Zip	Code) 21722
fmore Pages 1 Tent of He	ury or		20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 □ 1 □ Other (Specify)			ation (Name of atory or other place) wn Park	2007	7 Hai	Location - City or To gerstown	, MD
Depart	any inj once.	1	21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	, 17:	22. E	Name and Address Oonald Ed Lear Spr	of Facility Iwin Tho Ling, MI	ompson Fi	uneral H	ome, Inc
Physi /Med Exam	dical iner	liner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, is adding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	Scleio (sequence of):	KE COOL	lò vas	respiratory arrest,	lown	Approximate Interval Between Onset and Death
tificate be executed g physician and		edical Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of);					
The law requires that the death certification has been signed by the attending plant.		Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of predictions of the control	etal death 3 1	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
quires that	should be det	δ '	Part II. Other significant conditions co	ntributing to death but not n	resulting in the und	derlying cause given i	n Part I.	T .	use contribute to the	
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this Phys	di di	0	examiner?		☐ ER/Outpatient 28b. Time of	Out-		Residence		
Attending ir death.	the funer	Certification	1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)		Work? M 1 ☐ Yes	2 🗆 No	d. Describe how inju		
pital or Attenurs after deatl			4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	city)			f. Location (Street as City or Town, State	9)	
To the Hospital or within 24 hours afte To the Funeral Dir	9		one)	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death on nation and/or inve	stigation, in my opinio	on, death occurred	d due to the cause(s at the time, date an) and manner as sta d place, and due to t	ted. he cause(s)
To with	000		29b. Signature and Mig. 15 Mil.			29c. License nu D2	0 0 0	- 0 1	te signed (Month, D	ay, Year)
SH-10	State	1	11. Date filed (Month, Day, Year)	ampleted cause of death (It	Ylann	sa lunia	Arena	e Hage	Han	M) 21142
He	gistra		SEP 0 5 2	Will Bran	D. 19					

Birthplace (State or Foreign Country)

Mixed

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

Year

1√⊋Yes 2 □ No

/Medical Examiner

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-tra physician the as use by cate has been signed page 2 should be det certificate Physician: funeral director. After this or Attending

Division or Vital Records, P.O. Box 68760

Physician Arianna Sofia Ramos 4ULUST 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rocville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Pays 1 □ M 2√E F Hours Min. Director August 28. 2007 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11478 Applegrath Way 20876 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Guatemala El Slavador 1 Yes 2□ No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Felipe Ramos Rocio Pelaez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rocio Ramos- Mother 11478 Applegrath Way, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 4, 2007 Germantown, MD <u>'s Cemetery</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1040 Rockville Pike Rockville, MD 20852 se Im 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OF GREAT ARTERIES TRANSPOSITION Due to (or as a consequence of): Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □ Ectopic pregnancy 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year 2 Accident 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

M. SUKUMAR 31. Date filed (Months Pap Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SUKUMHR MD 9901 Medical center Drive Rockville MD 2085C Raistrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 01, 200; **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Hebrew Home of Greater Washington Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 7/6/1923 Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Min. 195-18-4804 PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Chevy Chase 1 XYes 2 No MD Montgomery Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5630 Wisconsin Avenue #802 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ☐ Yes 2**X** No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drug Stores 12 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alex Robinson Leona Rom ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 Summer Mill Court #802 Bethesda MD 20817 Bruce Robinson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 9/5/07 Clarksburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No page 2 autopsy perform certificate 2 **1** No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Medical Certification: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient After this 28a. Date of Injury (Month, Day Year) funeral 27. Monny of Death 1 Matural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in within 24 hours at To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. (Check only one) To the I D 35 4 36 29d. Date signed (Month, Day, Year) SEPTEKPSEROI, 2007 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Begistrar's Signature

32

2007

ONTROSERD, RECKVILLE, MD2085

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHANKS **Physician** 746U7 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE 8. Date of Birth (Month. Day, Year) 7-25-30 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours MASSACHUSETTS 1 M 2 X 027-24-6265 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Instrument if Item 27 is marked other than "naturel; or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinator and be notified at once. 10a. State 10b. County 1 Yes 2 □ No LARGO PRINCE GEORGE Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20774 U. S. A. 158 JOYCETON TERRACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 Widowed 4 NDivorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE SECRETARY STATE DEPARTMENT YEAR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CATHERINE RIVERS CECIL N. DRAYTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WASH., DC 20003 FREDERICK A, DRAYTON-BROTHER 909 - E ST., S. E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9-10-07 HARMONY MEMO. PARK LANDOVER, MD 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 21. Signature of Euneral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part1. Enter the disease, or complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ettending physicien and for use es the buriel-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant, 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ete hes been signed by the e page 2 should be detached i 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 70 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 1 Natural 28b. Time of 28d. Describe how injury occurred ne Hospitei or Attending Pl n 24 hours after death. ne Funerai Director: Atter ti Certification; 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 01, 2007 Type, Print HOW TROSE ROAD, ROCK VILLE, HD 20852 Name and address of person BARBARAKALA Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2007 0 Registrar

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State of Maryla	and / Department of He	ealth and Mental Hygiene

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Physician/	Ϊ	Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year OOFO her
Medical Examine		Demetri Kay Stover a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	August 2, 2	2007 0250 hrs 4c. County of Death
		University of Maryland Medical Center	Baltimore	ş*	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of Birt	h(MMDD/YYYY) 9. Birthplace (State or Foreign Country) Pennsylvan
Director		10 10, 1314	rs.	March	6,196 Foreign Country) Pennsylvan
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215-0036 be filed within 72 hours after death with the Maryland mild Hygiens whed other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. Re Compilated by Firneral Director	ָ בַּ	10/10 New Hampshire Ave.	10f. Zip Code 20903	10	Og. Citizen of What Country? United States
with the is 23a of contification in its 23a of contificati		Marital Status 12. Was Decedent Ever in U.S. 13. V	/as Decedent of Hispanic Origin?		14. Race - American Indian, Black,
or items 23		1 Yes 2 No	Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)	White, etc.
"natural", CExamine:	<u> </u>	or Dates:	Yes 2 No specify:	d of work done	Specify: Black
		Flementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use		ne T is it
within iene.	5		llerk	Jame (First Middle 1	U.S. Treasury Dept.
21215-0036 Util be filed within 7 Mental Hygiene, marked other than cevent, the Medica		7. Father's Name (First, Middle, Last) Leroy Stover, Sr.		vame (First, Middle, M	o 4 d
2 pg & 5	2	9a. Informant's Time/Relationship (Type, Print)		er or Ru al Route Num	nber, City or Town, State, Zip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	-		osition (Name of cemetery,	Date Date	Juer Spring, Md. 20903
			0 ()		
Baltimore permit, Pages 1 & Department of Ht Important: If it injury or other t	ŀ	1. Signature of Funeral Service Licensee 22	Name and Address of Facility	Phillip Roll	Riverdale, Md. Funeral Service
Balt permit Departi Import injury		3a. Part I. Enter the disease or complications that caused the death. Do not enter	4902 Stan Haven	Rd. Tem	ole Hills, Md. 20748
Physician /Medical		failure. List only one cause on each line.	r the mode of dying, such as card	diac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and Death
xaminer		mmediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of):			
		Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):			
ed nisit		ause. Enter Underlying Cause			e .
d d ansit	בא	events resulting in death) Last Due to (or as a consequence of):			
60, e be executed ysician and burial - transi	ealical	UNPENDED X AMENDED #2 PER ME 9/5/07	CCHD DB		
68760 certificate b riding physise as the bu	/ Me	F FEMALE: 3b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic p	regnancy	23d. Date of delivery Month Day Year
, Box 6876 the death certificate by the attending phy ched for use as the behavioring that	Clar	past 12 months? 4 Pregnant at time of death 5	Fetal death 3Ectopic p Other (Specify)		World! Day Foar
the death c the death c the death c the death c the atten	5	Yes 2 No 9 Unknown g Unknown	e underlying cause given in Part	I. 23e. Did to	obacco use contribute to the cause of death?
P.C es that igned to detail	2				s 2 🗸 No 3 Probably 4 Unknown
of Vital Records, Ig Physician: The law requir Wer this certificate has been s meral director, page 2 should 1	Completed			24a. Was autop	
Reco	E O		-	perfo 1 ✓ Yes	rmed? death? 2 No 1 Ves 2 No
tal F	De-	5. Was case referred to medical examiner?	26.Place of Death (C		
of Vir	٩.	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 17. Manner of Death 28a. Date of Injury 28b. Time of	sit 5 BOA T		Residence 6 Other:
on c tending sath. or: Af		1 Natural 5 Pending Aug 18, 2007 2230 hrs	1 Yes 2 🗸 N	Subject ass	aulted
Division tal or Attendir rs after death. al Director: A led in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, si	reet, factory, office building, etc.	or Town, S	Street and Number or Rural Route Number, City State)
ospital hours wmeral ly filled	- 1	4 Homicide determined (Specify) Jail/Penal	curred at the time, date and place		trive, Upper Marlboro, MD
the H thin 24 the Fi mplete	Medical	Check only 2 Medical Examiner: On the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investigned manner stated.			
F. 18 T. 0	<u>§</u>	9b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		Whing Grasself, MB	O.C.M.E.		August 24, 2007
&B		60. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111	Penn Street, Baltimore,	MD 21201	
<1)() Stat	te	81. Date filed (Month, Pay, Year) 5 200 32. Resistrar's Signature			
Registra	ar	OLI OU LOUI PARTIE DE PA			

OCME

and manner stated

Stoner

32. Registrar's Signature

18. Mother's Name (First, Middle, Maiden Surname) Zelma Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2237 Nicodemus Road Westminster, MD 21157 09/06t/2007 20c. Location - City or Town, State Hampstead, MD Princes Affine Fally Home and Chapel, P.A. Westminster, MD 21157 Approximate Interval Between Onset and Death Marting 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Carroll

14. Race - American Indian,

White

Black, White, etc.

4c. County of Death

10g. Citizen of What Country?

USA

Specify

16b. Kind of Business/Industry

Own Home

1520

MD

1 ☐ Yes 2 XNo

10d. Inside City Limits

Birthplace (State or Foreign Country)

MIL 12 State

Registrar

Medical

3 ☐ Suicide

29a. Certifier (Check only

4 ☐ Homicide

29b. Signature and title of Atifier

31. Date filed (Month, Day,

6 ☐ Could not be

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Division of Vital Records, P.O. Box 68760, within 2

3altimore, Maryland 21215-0036

29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0059903 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person AVE North ECO+MD2190

State Registrar

32. Refistrar's Signature 31. Date filed (Month, Day, SEP 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of F rtificate of			ene ND D D 7	20055	
	Physic /Medi		Decedent's Name (First, Middle, I	,	da D. Stout			2. Date of Death Month	Day Year 1, 2007	3. Time of Death 1:10 A M	
	Exami		4a. Facility Name (If not institution, g	ive street and number Asbury Circle)	4b. City, Town, o	or Location of Death		4c. County of Death		
-74	Funeral Director		5. Social Security Number 6. 213-32-9662	Sex 7. A	ge (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo Apr 4, 19	9. Birth Cou 35 Sot	place (State or Foreign ntry) uth Carolina	
	laryland show	'n	Usual Residence of Decedent 10a. State 10b. County MD C	alvert	10c. City, Town or Lo	cation	Solomons			10d. Inside City Limits 1 □ Yes 2 📉 No	
	with the IV a or 28a-f t be notifie	Direct	10e. Street and Number	Rm 100		10f. Zip Code	20688	10g	Citizen of What Cou	ntry?	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	l No	Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No	dispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	can Indian, etc.	
21215-0036	filed within 72 ho Hygiene. ther than "natur ent, the Medical I	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or	(Give		oation during most of word d) emaker	king 16	b. Kind of Business/In	wn Home	
Maryland 2	12 should be filed within hand Mental Hygiene. 7 is marked other than "fraumatic event, the Mec	To Be Co	17. Father's Name (First, Middle, La	Rowell Dor	sett		18. Mother's Nam	ne (First, Middle, Mai Mary	den Surname) Burton		
	1 and 2 shou Health and I tem 27 is ma		19a. Informant's Name/Relationship Sarah Vess /Daughte					ral Route Number, C rk, MD 20653	ity or Town, State, Zij	o Code)	
Baltimore,	Pa ant:		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			sition <i>(Name of</i> natory or other plac tan Crematory	1 00	Date 200 /31/07	Location - City or To Alexandr	ŕ	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lic	derick, MD 206	78						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart fallure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ine.	er the mode of dyir		or respiratory arrest,		Approximate Interval Between Onset and Death	
68760,	ficate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence of):						
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	Ectopic pregnanc) Other (specify)	1		23d. Date of delive	ery Day Year	
	w requires that been signed t should be det	by	Part II. Other significant conditions	contributing to death I	out not resulting in the ur	nderlying cause giv	en in Part I.		co use contribute to t	he cause of death?	
or Vital Records,		Completed	1					24a. Was an autopsy performed	s an 24b. Were autopsy findings availab prior to completion of cause of death?		
V:I) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatien	t 3□ DOA Oth	or.	th (Check only one)			
on or	Attending Phys r death. ector: After this by the funeral dii	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury 28b. Time of	28c. Injur Wor	4 Li Nursing Ho	28d. Describe how i	e 6 □Other (Specit njury occurred	<u>(y) </u>	
Division	al or Attend s after death. al Director: ,	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of in	jury - At home, farm, stre tc. (<i>Specify</i>)			28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,	
		Medical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Example	hysician: To the best miner: On the basis of and manner si	of my knowledge, death of examination and/or in- ated.	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the caus rred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)	
	To the within To the comp	Ň	29b. Signature and title of certifier			29c. License			Date signed (Month,	* '	
w)	ID		30. Name and address of person wh		death (Item 23a) (Type, I	Print)	Prince	Frederic	3/31/2007 Ky MD 2	0678	
	Sta Registr	te	31. Date filed (Month, Day, Year)	U /	Signature	Marke .	1. 11100	1	1 100		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Roxanne Marie Scheuch 2007 /Medical eptember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛣 F 236-90-6287 51 Director 6/01/1956 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified of once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Berkeley Martinsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 844 Beddington Rd. USA I 14. Race - American Indian, Funeral 25404 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican. etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Leon Scheuch, Sr. Roxie Sherman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Scheuch 844 Beddington Rd., Martinsburg, WV 25404 of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OMPS Crematory 9/6/07 Winchester, VA 4 □ Donation 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. 21. Signature of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final distance or condition resulting in death) SRP315 Physician /Medical Due to (or as a consequence of): obstructive Examiner Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Extensive Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Men. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Marbid 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of certificate has b rector, page 2 s death? 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 To the

State Registrar

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUNITHED

32. Registrar's Signature

29c. License number

10060396

29d. Date signed (Month, Day, Year)

09/05/07

opal

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at one.
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Examiner

Division or Vital Records, P.O. Box 68760,

BA 40+1 State Registra

	Registrar				Ce	rtificate of l	Death			Reg. No.	2007	299	5/
	1. Decedent's Nar	me (First, Middl	le, Last)						2. Date of D Month		Van	3. Time of Do	eath
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	313 Blu	e Heron	Court			Ocean Ci	.ty			W	orcester		
ral	5. Social Security	Number	6. Sex	7. Age (In yrs. I	ast birthday,	If Under 1 Year	If Under 2		8. Date of Bi	irth	9. Birthp	lace (State or F	oreign
or	159-28-0	838	1 √ M 2□ F	73	Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, D) 4/10/1	934	Coun	PA	
once. To Be Completed by Funeral Director	Usual Residence												
_	10a. State	10b. County			, Town or Lo							0d. Inside City	
5	PA	Mont	gomery	Pei	nnsbur	g, Marlbo	rough	Twp	•	1			₹ No
Director	10e. Street and N	umber				10f. Zip Code			10g. Citizen of What Country?				
<u></u>	3481 Fi	nland R	kd.			18073					USA		
Funeral	11. Marital Status		12. Was Dec Armed F	cedent Ever in U.S orces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig an, Mexican,	in? (Spe Puerto i	cify Yes or N Rican, etc.)	0-	14. Race - Americ Black, White,		
		rried 2 XMar	If Yes, G	2 ☐ No ive	1 ☐ Yes 2 ☑ No Specify:						Specify: Whi		
d by	3 ∐ Widowed	4 Divorced		Dates:									
Completed	(Spe	15. Deceden ecify only highe	it's Education est grade completed,) 1	(Give	dent's Usual Occupa kind of work done o	durina most	of workir	ng	16b. Ki	ind of Business/Ind	dustry	
E	Elementary/Sec		College	(1-4or 5+)		DO NOT use retired	,					•	
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Be			•					_			Surname)		
P	Edward				T 400 NA 111				ta Lev				
	19a. Informant's i				1	ng Address (Street a							_
1	Grace S		/ wile	20h P		Finland position (Name of	Road,		nsburg				р.
		•	3 Removal from	C.	emetery, cre	matory or other plac	:e)	D	ale	200. L0	ecation - City or To	wn, State	
		5 Other (S		Whit	temars	h Mem. Pa	rk 9	<u>/7/2</u>	007	Amb.	ler, PA		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home												
	file	UZ	forms	W_		08 Willia					1811		
	3a Part1. Enter shock, or he	the discovery eart failure.	only one cause on	caused the death each line.	. Do not en	ter the mode of dyin	g, such as o	cardiac o	r respiratory	arrest,		Approximate Interval Betwe	en
n	Immediate Cause disease or conditi	ion	a /	YOCAR	DIAL	INFR	RCT				FE	Onset and De	
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	Sequentially list conditions.												
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #10a-c,10e-f,perFH, 6872, 10/50CerFificate of Death Reg. No. 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** September 1 2007 12:55AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING HOME WORCESTER BERLIN 8. Date of Birth (Month, Day, Yea 3–28–1936 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🕅 F 161-30-5127 Yrs. PENNSYLVANIA 71 Director Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at MONROE Sussex 1 ☐ Yes 2 No Director Selbyville 10e. Street and Number 38414 Maple Lane 10f. Zip Code 10g. Citizen of What Country? UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Scott, Jane Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important; If item 27 is marked other than any injury or other treasment. COMPUTER CONSULTANT TECHNOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCES MOORE RICHARD ALMY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GERALD D. SCOTT/SPOUSE 817 BAY DRIVE, SUMMERLAND KEY, FL., 33042 20b. Place of Disposition (Name of cemetery, crematory or other place)
CAPE HENLOPEN
CREMATORY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 Removal from State 9-3-2007 FRANKFORD, DELAWARE 4 Donation 5 ther (Specify) 21. Sign sture of Funeral MELSON FUNERAL SERVICES, THATCHER ST., FRANKFORD, DELAWARE 19945 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** loid /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner sician and burial-transit certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death □Yes 5 ☐ Other (specify) the 9 Unknow ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ 🕽 known Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has was an autopsy performed? Yes 2 1000 certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Suursing Home 5 Residence 6 Other (Specify) 2000 2 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 769 who completed cause of death (Item 23a) (Type, Print) Courted Highwy Fewret Island De 1994 KA 10

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

SEP 0 4

2007

32. Registrar's Signature

			1- State of Maryland / Department of Health a Certificate of Death		, ,		20050
ī	Physici	an	1. Decedent's Name (First, Middle, Last) CHARLES E. SNOWDEN, Sr		Date of Death	28 ^{Day} 200 ^Y 7	3. Fine of Beach
100	/Medic Examin		4a. Facility Name (If not institution, give street and number) Montgomery General Hospital 4b. City, Town, or Location of Olney			4c. County of Death	n
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	r 24 Hrs. 8.	Date of Birth	9. Birth	oriski nplace (State or Foreign untry) aryland
l	Director		220-28-6275	F	eb.13	8,1931 M	aryland
	e Maryland a-f show tifled at	ctor	10a. State				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	I Director	10e. Street and Number 10f. Zip Code 20905	5	10	0g. Citizen of What Co	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 1 □ Ves 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates:	rigin? (Specify an, Puerto Rica	Yes or No- an, etc.)	14. Race - Amer Black, White	ican Indian,
2-00	72 hou "natura dical E	eted	15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during mos life. DO NOT use retired)	st of working	91	16b. Kind of Business/I	
Maryland 21215-0036	d within giene. er than the Me	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) Cement Finish			Montg. Co Road Dep	
and	d be file ental Hy red oth	Be		ner's Name <i>(Fi</i> Ctha E		Maiden Surname) Je 11	
ary	shoul nd Me mark	T ₀					in Sodel -
ž,	and 2 salth a 27 is er trai		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Numb Jacqueline A. Snowden (Wife) 58 Norwood	Road,	Silv	ver Sprin	gon Bro
Baltimore,	Expess 1 at the transfer of th		4 Donation 3 Dotter (Specify)	9/6/0	7 8	20c. Location - City or Sandy Spr THNEPAL H	ing,MD
Bai	Depar Impor any Ir		21. In a graphiture of Funeral Services clicens of Facility (Company) (Compa	ngton	St,Ro	ckville,	MD 20850
Į.	8		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or hyart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
)	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Small CELL UND INCER Due to (or as a consequence of):	EXTE	NSIJE	STAGE	
	Examiner	er	Sequentially list conditions, from leading to immediate b. Due to (or as a consequence of)				
	ecuted and -transit	Examiner	Sequentially list conditions, for the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
68760,	ifficate be executed g physician and as the burial-transit	edical E	d.				
	ertifica ing ph e as th	Medi	IF FEMALE:				
P.O. Box	ie law requires that the death certificate be executed has been signed by the attending physician and je 2 should be detached for use as the bunal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of deli Month	very Day Year
rds, P	equires that en signed b ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	I.		pacco use contribute to es 2 ☐ No 3 Pr	the cause of death? obably 4 □Unknown
Division or Vital Records,	The law recate has be page 2 sho	Completed			24a. Was ar autops perform 1∐ Yes 2	n 24b. Were au prior to death? 2 Y No 1 □ Yes	topsy findings available completion of cause of
Vita	siclan certific rector,	Be	examiner? Hospital: /	e of Death (C			
on or	iding Phys h. After this funeral di	tion: To	1 Yes 2 No No No No No No No	28d		ence 6 Other (Spec ow injury occurred	cify)
Divisi	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	e Hospii 24 hour e Funera etely fille	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.				
	To th Within To th comp	Me	29b. Signature and title of certifier 29c. License number			9d. Date signed (Monti	h, Day, Year)
	6		MD D356	35	L	tucust 2	£005,8
			30 Name and address of person who completed cause of death (Item 23a) (Type, Print) OSEPU KAPLAN, MS 18111 Print Philip	DR	0(N	ey, mo	20832
	Sta Registi		31. Date filed (Month, Day, Year) SEP - 4 2007				

DHMH 17 Rev 1/2001

ORIGINAL

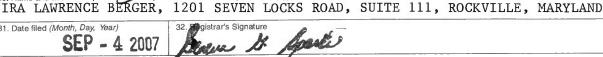
within 2 8

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State

Registrar

29c. License number

044157

29d. Date signed (Month, Day, Year)

20854

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month NANCY GERTRUDE SALINS SEPTEMBER 3, 2007 9:18 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F Director 578-34-6631 78 12/18/1928 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at Director 1X Yes 2 No MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14510 HOMECREST ROAD #1003 20906 U.S.A. Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: 3 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than 12 COLLECTOR RETAIL CREDIT DEPARTMENT rmit. Pages 1 and 2 should be filed w spartment of Health and Mental Hygie portant: If item 27 is marked other tily Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISADORE O. BAREZOFSKY SARA BLENDMAN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMAN JOSEPH SALINS/HUSBAND 14510 HOMECREST RD #1003, SILVER SPRING, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State permit. Page Department o Important: If a JUDEAN MEML GDNS 09/05/2007 OLNEY, MARYLAND 9 4 Domation 5 ☐ Other (Specify) 2). Signat DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final **Physician** Advanced disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to (or as a consequence of). Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas 25. Wa as referred to medical examiner? certificate ha autopsy performed? death? 1 ☐ Yes 2 ☐ No Division or Vital 1 Yes 21 No Physician: funeral director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Directors. completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dlandwood Covert Olwey, Haryland WoodevardJR 3416 ARTHUR 31. Date filed (Month, Day, Year! Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

		1	For Stete Registrar	State	of Maryland	•	artment of H		Mental Hygid	2007	29962			
			Decedent's Name (First, Middle	, Last)					2. Date of Death	Day Year	3. Time of Death			
ı	Physicia		Pauline D.	Shumaker					August	26, 2007	4:30 P M			
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location of Death		4c. County of Dea	th			
	Lxaiiiii		Genesis Nursing	Home			LaPlata			Charles				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ist birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	(ear) 9. Bit	thplace (State or Foreign			
	Director		204-10-6289	1 ☐ M 2 X F	92	Yrs.	Months Days	Hours Min.	Aug. 16,	1915 Per	nsylvania			
	ט		Usual Residence of Decedent								And Innide City Limits			
	nylan how		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits 1X Yes 2 □ No			
	a-fe	cto	PA Somer	rset	Sal	isbury	7							
	or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	ountry?			
	23a (23a (23a (23a (23a (23a (23a (23a (141 Grant St.				15558			USA				
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Modeal Examinating traumatic event, the Modeal Examinating traumatic event, the Modeal Examination and the Modeal Examinati	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U.S Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi				
9	or it	F	1 Never Married 2 Marr	If Yes, C	2 🔀 No Sive		1 ☐ Yes 2 ☑ No	Specify:		Specify: Tall	hite			
ğ	ural',	d by	3 X Widowed 4 ☐ Divorced	Year or	Dates:				1.4					
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2	within ene. than "	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)			"		O !!				
	e filed within al Hygiene. I other than ' vent, the war		12. Father's Name (First, Middle,	(ast)		Homer	naker	18 Mother's Nam	ne (First, Middle, M	Own Home				
2	be fi	Be	_	Lasi				Miriam H						
$\frac{8}{5}$	2 should be and Mental Is marked or raumatic ever	ဥ	Lester Deal			405 14-10	4 11 (Chrone			City or Town, State,	Zin Code)			
Maryland	2 sh and ' is m		19a. Informant's Name/Relations	1 1 2	.00				Hughesv		20637			
	1 and Health tem 27 lem		Sally A. Younk	in/ Daugin			sition (Name of	weet Dr.	-	Oc. Location - City o				
9	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1	3 □Removal from	m State	metery, cre	matory or other plac	i i	12-2	•				
틸	men men tant:		* 4 □Donation 5 □ Other (S		Uni		metery			Meyersdal				
Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any Injury or other once.		21. Signature of Tuneral Service	Licensee) eur	~w				wman Fune: sbury, PA	ral Home, 15558	Inc.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or headfailure. List only one cause on each line. Approximate Interval Between Onset and Death disease (Final disease (Final disease))											
	Fnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):											
0	Examiner				, , , , , , , , , , , , , , , , , , , ,	,								
		ē	Sequentially list conditions, if any, leading to immediate	b. Due t	to (or as a consequ	ience of):								
	cate be executed oblysician and the burlal-transit	Examiner	Cause (Disease or injury that initiated events											
	ate be executed hysician and the burlal-transit	Exa	resulting in death) Last	Due t	o (or as a consequ	ience of):								
8760,	sicia bur	dical		d	_									
687	ficate g phy is the	edic												
	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	an/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		7			23d. Date of d	elivery			
Вох	atter for t	ciar	in the past 12 months? 1 Yes 2 No		e birth 2 🗀 Fetal egnant at time of de		□Ectopic pregnancy □ Other (specify)			Month	Day Year			
o.	the d y the	Physici	1 ☐ Yes 2X No 9 ☐ Unknown											
4	s that the de ned by the a detached f		Part II, Other significent conditi	ılting in the u	ınderiying cause gıv	en in Part I.	23e. Did tob	acco use contribute	ontribute to the cause of death?					
ds	sign sign d be	d by	De	mentir					1 □ Ye:	s 2 🗆 No 3 🗀 I	Probably 4 Unknown			
Vital Records,	v require been si should l	Completed	1000	tive	travet	ail	ule		24a. Was an	24b. Were	autopsy findings available			
360	The lav	mp		31776	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7			autopsy perform 1 Yes 2	prior to	completion of cause of			
al F			1			1					es 2 No			
ZĬ.	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital			Ott	1 - 24	ath (Check only one					
of	hys his	J.	1 Yes 2 No	1 11	☐ Inpatient 2 ☐	ER/Outpatie 28b. Time (nt 3 DOA	Nursing F	28d. Describe ho	nce 6 Other (Sp	pecify)			
	ing f	on	27. Manner of Death 1 Natural 5 Pendi	19	te of Injury onth, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 2000. 30 110	ii iiijary oooairoa				
Division	al or Attending P s efter death, il Director: After t id in by the funera	Certification:	2 Accident investi 3 Suicide 6 Could	not be	44.5			163 2 140	28f Location (Str	and Number or	t and Number or Rural Route Number			
Ξ	fter direct	E	4 Homicide determ	-in 289. Pla	ace of Injury - At ho ilding, etc. (Specif)	me, rarm, s	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending within 24 hours efter death, To the Funeral Director: After completely filled in by the fune		20 0 10						and due to the	uso(a) and annua	as stated			
	Hosp 4 hol Fune ely fi	edical	(Check only 2 Medical	Exeminer: On the	basis of examinat	wiedge, dea tion and/or ii	th occurred at the til evestigation, in my o	me, date and place ppinion, death occu	rred at the time, da	use(s) and manner te and place, and d	ue to the cause(s)			
	the the	Med	one)		anner stated.		29c. Licens	se number	29	d. Date signed (Mo	nth, Dey, Year)			
	J S S S S	-	29b. Signature and title of certific	10.	1.10				•	012010)			
ŧ			- July	and I	MD		Do	06165	2	0/2010	/			
			30. Name and address of person		ause of death (Item		Print)	hen let	mbe o	y, wedde	d un 2-1-2			
			ATOL KATH	n_{-}, co	1.07	304,	11350	pemos	المالي المالي	/ water	11111120608			
		ate	31. Date filed (Month, Day, Year		. Registrar's Signa	ture	A . 114 .	٧			V			
	Regist	rar	OLF	5 2007	A SHOW	R. 4								

		1 - For Stata Registrar	State of Ma	rylan		artment rtificate			and M		iene g. No.	07	29963
Physi /Med		Decedent's Name (First, Middle, Last) Harry Ross	Smith SR							2. Date of Dea Month Septemb	Day	Year 007	3. Time of Death 16:55 Р м
Exam	iner	4a. Facility Name (If not institution, give s WMHS Braddock Ca	mpus			Cum	eber			4c. County of Death Allegany			ny
Funera Directo		5. Social Security Number 220-07-6582 1怪 Usual Residence of Decedent		(In yrs. I 88	ast birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth Aug. 23	1919	Col	place (State or Foreign intry) Tyland
Maryland 8-f ehow	tor	10a. State 10b. County Allegany			, Town or Lo Barton								10d. Inside City Limits 1 ☐ Yes 2 No
ith with the 23s or 28	ai Director	10e. Street and Number 20211 New Georges	Creek Ro	ad		10f. Zip	Code 2152	1			og. Citizen of United		•
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or iteme 23s or 28s-f show eny injury or other traumatic event, its Medical Exercise from the netified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1			Was Deced f Yes, spec 1 ☐ Yes 2		panic Orig , Mexican Specify:	gin? (Spe , Puerto l	ocify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc. nite
Maryland 21215-0036 a 2 should be filed within 72 hours at th and Mental Hygiene. 7 Is marked other than "natural; or traumatic event, its Medical Expen	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) UNKNOWN		-)		dent's Usua kind of word DO NOT us Inspec	k done di e retired)	tion uring most	of workir	ng	16b. Kind of B Paper M		acturer
aryland should be file and Mental Hy americe othe umatic event	To Be (17. Father's Name (First, Middle, Last) Joseph Smith							r's Name ara	(First, Middle, I		ne)	
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Ty) Benjamin Smith/ so			Rt. 1	, Box	164			Route Number West			ip Code) 26726
altimore, mit. Peges 1 ar partment of Hea portent: If Item y Injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		ce	lace of Disposemetery, cremoerland	d Crei	mato:	rу	09 / 200	05/ 7		land	own, State Maryland
Deparmit Departiment		21. Signature of Funeral Service License	Good		1	11 Chi	urch	St.,	Wes	l Funer ternpor	t, Mary		21562
B760, sate be executed /Medica Examinet physicien and the burial-transit	Examiner	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ience of):	l Og	of dying	such you	cardiac of	r respiratory arre	est,		Approximate Interval Between Onset and Death
death certific	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)						23d. Date of delivery Month Day Yea			
S, Se the se the se the se de	Ď	Part II. Other significant conditions con	nderlying ca	use giver	n in Part I.		23e. Did tobacco use contribute to the cause of death. 1 Yes 2 No 3 Probably 4 Unknown						
The law the hes b	Completed			-	24a. Was an autopsy performer			y ned?					
VISION OF VITAL IN Attending Physicien: The rideath. ector: After this certificete by the funeral director, pag	ation: To Be	25. Was case ferred to medical examiner? 1 Yes 2 No 27. Manner of ath 1 Natural 5 Pending 2 Accident investigation	ospital: Inpatien 28a. ate Injury (Month, Day		ER/Outpatient 28b. Time of Injury		Cther Sc. Injury Work?	4 □ Nur	sing Horr	Check only on ne 5 - Reside 8d. Describe ho	ince 6 □Oth		fy)
DIVISION of or Attending s after death. in Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injur building, etc.	y - At hor (Specify)	me, farm, stre	eet, factory,	office		2	8f. Location (St. City or Town	reet and Numb , State)	er or Rur	al Route Number,
To the Hospitei or within 24 hours after To the Funerei Dire completely filled in h	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of er: On the basis of e and manner state	xa mınatı	vtedge, death on and/or inv	occurred a estigation,	t the time in my opi	, date and nion, death	place, a	nd due to the ca	use(s) and ma ate and place,	anner as : and due !	stated. to the cause(s)
To t To t	Z.	29b. Signature and title of contifier	MA	7		29c.	License DC		591	63 6	od. Date signer	2 (Month)	Day, Year)
	+VA	30. Name and address of person who cor Dr. Shin Eung Kim,	90 Main	St,	Wester		, Ma	rylar	nd /2	1562	1	,	
St Regis	ate rar	31. Date filed (Month, Day, Year) SEP = 5 2	32. Registrar	s Signati	ure	San Se	0						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 Septembe George Henry Timmons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PALISBURY PENINSULA KEGIONAC MEDICAL Wicomica LENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1**X** M 2 □ F 10/7/1935 MD 71 Director 215-36-1384 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County show 28a-f shov notified at 1 ☐ Yes 2 No Director Willards MD Wicomico the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. o e USA 21874 8635 Burnt Mill Rd. by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1x Yes 2 ☐ If Yes, Give Year or Dates: 2□ No 1 Never Married 2 Married 1 ☐ Yes 2 No than "natural", or Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Painter item 27 is marked other other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Julia Ann Freeman Horace Albert Timmons ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Timmons / wife 8635 Burnt Mill Rd., Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any injury or otl once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 9/7/2007 Lewis Cemetery Willards, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lurbage Funeral Home 21. Signature of Fy ral Service Licensee 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as onsequence of) /Medical Examiner Sequentially list conditions, if any, leading to infine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2□ No 3 Drobably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes 2 J. M. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2[] NO Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 5 ☐ Pending investigation .1- Natural 1 □ Yes 2 □ No 2 Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and line of certifier

BA i gratis

215-36-1384

State Registrar ELLEDA

SFP 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

32. Registrar's Signature

100 E. Carroll ST.

Salisbury, md. 21801

			For State Registrar	State of Mary		rtment of H			ene 2007	29965			
	Physici		Decedent's Name (First, Middle, Eva Louise Tine					2. Date of Death Month	Day Year 23 2007	4.4			
9	/Medic Examin		4a. Facility Name (If not institution, Atlantic Genera	give street and number)		4b. City, Town, or Berlin	Location of Death	Aug	4c. County of Death Worcesto				
	Funeral Director		5. Social Security Number 217–42–5647	5. Sex 7. Age (II	n yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept 13,	(ear) 9. Birthp Cour	lace (State or Foreign try) MD			
	death with the Maryland ms 23a or 28a-f ehow must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Worces		oc. City, Town or Lo Berlin	cation			1	0d. Inside City Limits 1 ☐ Yes 2▼ No			
	with the	i Director	10e. Street and Number 8835 Ironshire S	Station Rd		10f. Zip Code 21811		10g	g. Citizen of What Cour	ntry?			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 ie marked other then "netural", or Items 23a or 28a-f ehow any injury or other treumatic event, Ite Medical Examinar must be multied at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces?	1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.			
Maryland 21215-0036	thin 72 hou e. en "netura Veulcal E	Completed I	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	luring most of work)	ung 16	Black, White, etc. Specify: Black 16b. Kind of Business/Industry Public Education idde, Maiden Sumame) ell umber, City or Town, State, Zip Code) Berlin, MD 21811 20c. Location - City or Town, State Berlin, MD				
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arylar	should be and Menta marked sumatic ev	ToB	unknown Gladys Briddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	ages 1 and 2 nt of Health a t: if item 27 is f or other tre		Charles A. Tind 20a. Method of Disposition 1 Seurial 2 Cremation	B □Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	θ)	Date 20	c. Location - City or To				
Baltimore,	permit. P. Departme Importent any njury once.		4 Donation 5 Other (Sp. 21. Signature of Funeral Service)	censee	L	Name and Addres	s of Facility latson Fu	neral Hom	e				
اه	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that caused the nly one cause on each line.	death. Do not ent	13 .	g, such as cardiac	0.	1,	Interval Between Onset and Death			
18760, 8760, E	Medical Examiner bhysicien and the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co		Penal 1	Distore			Year.			
7/3/173 7/23/20 .O. Box 6	requires that the death certific been signed by the attending p should be detached for use as it	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/nths? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year			
8, P	requires that the een signed by th nould be detache	ed by Ph	Part II. Other significant condition	s contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		acco use contribute to the cause of death? s 2 No 3 Probably 4 Minknown				
Seco	The lay ate hes page 2	Completed						24a. Was an autopsy performe	24b. Were auto prior to co death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of			
i N か L C リア ジェダ f Vital F	ysician is certifi director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 X ER/Outpatier		er: 4 🗌 Nursing Ho	th <i>Check only one</i> ome 5 Residen	ce 6 □Other (Specif	(y)			
イーイート サイル Division o	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification:	27. Manner of Death 1	ot be 280 Place of Injury	- At home, farm, str	M 1 🗆	yat k? Yes 2 □No	28d. Describe how 28f. Location (Stre City or Town,	eet and Number or Rura	al Route Number,			
7 0	Hospitel o 24 hours af Funeral D tely filled in	Medical Cer	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of n	amination and/or in	n occurred at the tin	ne, date and place, pinion, death occur	and due to the cau	ise(s) and manner as s e and place, and due to	tated. o the cause(s)			
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated		29c. Licens	8067	290	d. Date signed (Month,	Day, Year)			
	5 m		Nicholas Boi	no completed cause of deat	h (Item 23a) (Type,	Print) Coade	d Helin	y Fran	ack Island	Pe19744			
	Sta Regist		31. Date filed (Month AUG 3	. 2007 32. Fagistrar's	Signature	barte	5 /						

nended		State Registrar # 1. Decedent's Nam		32 Per	pġ, go	Cei	rtificate	of L	Death)	2. Date of D	Reg. No	.ZUL	-	29966 3. Time of Death
Physicia		RICARD		LEON	VA1	ENTINE					Avaus-	+ 2		rear	DZ 04 4M
/Medic				give street and number			4b. City, T			of Death	0		c. County of		
		SAINT		ES HEAL			If Under 1			ORE	9 Date of B	lietle		O Dietheles	- (Chair as Fassius
Funeral Director		5. Social Security N 579-68-50		6. Sex 7.	Age (in yrs.	last birthday) Yrs.		Days	Hours	Min.	8. Date of B (Month, E 1-23-1	Day, Year)	Country)	e (State or Foreign
		Usual Residence o	of Decedent							1	1 23 1				
show	'n	10a. State MD	MONTGOM	(FRY		ty, Town or Lo								10d.	Inside City Limits 1 XYes 2 No
or 28a-f	Director	10e. Street and Nu					10f. Zip (Code				10g, Ci	itizen of Wh	nat Country	?
23a or ust be		15115 INT	TERLACHE	EN DR #910			209						J.S.A.		
Items ner m	by Funeral	11. Marital Status	ried 2 Marrie	12. Was Decede Armed Force	es? ⊒ No		Was Decede If Yes, specif	fy Cuba	ispanic O an, Mexica Specify	an, Puerto	ecify Yes or N Rican, etc.)	10-	Black,	American White, etc.	
natural", or		(Sne	15. Decedent's	s Education t grade completed)		16a. Deced	dent's Usual	Occupa	ation	et of work	ina	16b. H	Kind of Busi	iness/Indus	try
ene. than "r he Med	nple	Elementary/Seco		College (1-4d	or 5+)		kind of work DO NOT use		dring mo	St OI WOIK	ng				
at Hygier other th	Be Completed	17. Father's Name	(First, Middle, L	ast) 5+		MANA	GEMENT	<u>:</u>	18. Moth	er's Name	(First, Middl	le. Maide		ERNME	INT
mentar arked of atic eve	To Be	ALBERT LI		•						E STA	, ,	,	,		
item 27 is marked o		19a. Informant's N BETTY J.		1 1 21		1 .				OXON	al Route Num		,		ode)
int: If item		20a. Method of Dis	•	3 □Removal from Sta		Place of Dispo cemetery, crer	sition (Name matory or oth	e of ner plac	e)	15 ¹	Date	20c. L	ocation - C	ity or Town	, State
tant:		4 Donation	5 ☐ Other (Sp	ecify)	RI	VERDAL:			- ;	9- 11 -		1	ERDAL	-	
Important; If if any injury or once,		21. Signature of Fi	D- 4-	hall		7	474 LA	NDO	VER :	RD LA	JĒNKĪN	R, MD		5	
ysician		23a. Part1, Enter to shock, or hea Immediate Cause disease or condition resulting in death)	(Final	complications that cause only one cause on each		th. Do not ent	er the mode	of dyin	g, such a	s cardiac o	or respiratory	arrest,		In O	pproximate terval Between nset and Death . Kn W
Medical caminer		resulting in death)		Due to (or	as a consec	quence of):	1 he	no	ssha	se			. T	2	
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physic the b	dica		`	d					CERTIFICA	TION PARTY					
has been signed by the aftending physician and je 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2	2 months? □ No	23c. If yes, outcor 1 □Live birth 4 □ Pregnan 9 □ Unknown	n 2□Feta t at time of c	al death 3	Ectopic pre Other (spe	gnancy					23d. Date Mont		y Year
ed by detac	Ph			ns contributing to deatl	n but not res	sulting in the u	nderlying cau	ıse give	en in Part	I.	23e. Did	tobacco	use contrib	oute to the o	cause of death?
ed blu	d by										1]Yes 2	21 2 No 3	B ☐ Probabl	y 4 🗌 Unknown
2 shou	Completed										24a. Wa		24b. We	ere autopsy	findings available
ba	E O										per 1∐ Yes	opsy formed? 2 N	/ de	ath?	etion of cause of No
certificate rector, pag	Be	25. Was case reference examiner?		Hospital:				T Out		e of Death	(Check only	one)	-		
ral dir	٦.	1 Yes 27. Manufer of Dear		28a. Date of I		ER/Outpatien			4 ⊔ N		me 5 Res 28d. Describe				
e fune	ţi	1 Natural 2 X Accident	5 ☐ Pending investiga	(Month,	Day Year)	Injury unk	M	c. Injury Work 1 □ '	ເ?ື່ Yes 2.∐ັ	_	subject				
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ompletely filled in by the funeral director,	Medical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical E	Physician: To the be xaminer: On the basi and manner	s of examina	owledge, death ation and/or in	n occurred a vestigation, i	t the tin	ne, date a pinion, de	and place, eath occur	and due to th red at the time	e cause(e, date ar	s) and mani nd place, an	ner as state nd due to th	ed. e cause(s)
€	2	29b. Signature and	d title of certifier	- m	>				353				ate signed (
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07-06805 Kinte Veney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Medical Examiner 0335 hrs KINTE KHAREEN VENEY September 2, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4591 Allentown Road Suitland Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Fair Banks 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min Director 577-82-9893 Country) ALASKA XM 2 30 MAR 16,1977 Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1x Yes 2 No 28a-f show MD. P. G. COUNTY FT. WASHINGTON, MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 11402 Ft.SORATAGA COURT 20744 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. items must be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No 9 Yes AFRO AMERICAN Yes 2 X No specify Widowed Divorced If Yes. Give Year <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted permit: Pages I and 2 should be filled within 72 ho Department of Health and Menial Hygene. Important: If item 27 is marked and inition or a second permit in the property. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical Compl 12 Studend U.D.C A.C.Mehanice UDC Student 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) WEVELY VENEY COLEMAN Be SHERYT. VENEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WEVELY VENEY &SHERYL VENEY HALL RD. WARSAW, VA.22572 1082m SHANDY 20b. Place of Disposition (Name of Cemetery, 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) 9-8-2007 1 X Burial 2 Cremation 3 Removal from State 1156 Mulberry Rd. MULBERRY BAPT, CHURCH 9t8t007 Other Specify. Farnham, Va. 22460 Donation 5 21. Signature of Funeral Service Licensee CCo240 LEEFUNERAL, HOME Inc Warsay, Va 22572 2.2055 Amhard Tee Fineral Hone Tro.
caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part. Enter the disease, or complications that ca failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease *xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X AMENDED UNPENDED signed by the attending physician be detached for use as the burial TIEM#20b,22.perFH,G871,9/18/07,WS Box 68760, The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? this certificate Yes 2 ✓ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this nortifier 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 DOA Inpatient 2 Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes No 28a. Date of Injury (Month, Day Year) Sep 2, 2007 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Pedestrian struck by vehicle Natura 0320 hrs Yes 2 V No 5 Pending I Director: 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4591 Allentown Road , Sitland , MD (Specify) Local Street Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 2, 2007 . If me and address of person who completed cause of death (Item 23a) 5 Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

31. Date filed (Month, Day,

OCME

Registrar's Signature

E Ball Street

2007

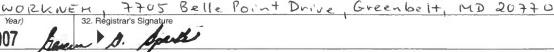
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		1 - State Registrar			rtificate of L		R	leg. No.	1 2330		
Physici /Medi		Decedent's Name (First, Middle, Last, Margaret	Wall	er			2. Date of Dea Month Septemb	Day Ye			
Examir		4a. Fecility Name (If not institution, give 26863 Waller Land									
Funeral Director		5. Social Security Number 6. Sec. 216-14-2421	7. Age (II	n yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Months)			9. (Year)	Birthplace (State or Foreig Country) [aryland		
show	or	Usuaf Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limit		
with the h e or 28e-i	Director	MD Somer:		Princes	10f. Zip Code	F 2	1	10g. Citizen of Wha	`		
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-f show event, it is Medical Examiner must be notified at	by Funeral	26863 Waller Land 11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No ff Yes, Give Year or Dates:	1	218. Was Decedent of Hi If Yes, specify Cubar 1□ Yes 22 No		ocify Yes or No- Rican, etc.)	Specify:	American Indian, Vhite, etc.		
within 72 houiene. than "natura the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Efementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired,	ation luring most of workii)	ng	16b. Kind of Busin	ess/Industry		
should be filed within of Mental Hygiene. marked other than imatic event, the Mental Hygiene.	Be	17. Father's Name (First, Middle, Last)	none	TOME	naker	18. Mother's Name		Maiden Sumame)	·		
12 should b h and Ment 7 Is marked reumatic e	To	Author Collins 19a. Informant's Name/Relationship (T)	rne Print)	19h Maifir	on Address (Street a	Ina Bell		ns r, City or Town, Sta	te Zin Code)		
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or any injury or other treumatic event, It a Medical Exampone.		Brian Waller/Son 20a. Method of Disposition 1 Agurial 2 Cremation 3 F	Removal from State	2681 20b. Place of Dispo cemetery, crei	53 Waller sition (Name of matory or other place	Lane, Pr	incess_	Anne MI) 20c. Location - City	21853 or Town, State		
permit. Pa Departmer Importent any injury once.		Asbury U.M. Cemetery 09/07/2007 Mt. Vernon, MI 21 Signature of Funeral Service Licensee M00295 Asbury U.M. Cemetery 09/07/2007 Mt. Vernon, MI 22 Name and Address of Facility Hinman Funeral Home 11673 Somerset Avenue, Princess Anne, MI									
Physician /Medical	l	d3a. Part1. Enter the disease, or complete shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)		death. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death		
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The law requires that rate has been signed b page 2 should be deta	Completed						24a. Was a autops perfor	sy prior med? deat	e autopsy findings availabl to completion of cause of h? Yes 2 \(\square\) No		
Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	Ar.	ath (Check only one)				
	tion; To	1 Yes 2 No. 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No				Home sidence 6 □Other (Specify) 28d. Describe how injury occurred				
lel or Attending Phy s after death. el Director: After this ed in by the funeral d	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Policy or Town, State)							r Rural Route Number,		
the Hospitel or nin 24 hours afte the Funerel Dir npletely filled in I	Medical (one) Medical Exami	sician: To the best of mer: On the basis of exand manner stated	amination and/or in	h occurred at the tim vestigation, in my op	ee, date and place, a pinion, death occurre	ed at the time, d	date and place, and	due to the cause(s)		
To the Youthin 2 To the Comple	Σ	29b. Signature and title of certifier	1-1		29c. License		2	9/4/07	fonth, Day, Year)		
EB		30. Name and address of person who co	ompleted cause of death			NERSIDE	E DR	SALIS	10815 DM		
Sta	ate	31. Date filed (Month, Day, Year) SEP 0 5 20	32. Registrar's	Signature							

CR (6)

State Registrar

31. Date filed (Month, Day, Year) **SEP 0 5 2007**



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

2007 29970

antes vvillatits	1- For State Of Maryland / Department of He Certificate of De Registrar	ath	g. No.
Physician/ al Examiner	Decedent's Name (First, Middle,Last)	2. Date of Death Month August 30,	Day Year
	4a. Facility Name (if not Institution, give street and number) 4b. C	ity, Town, or Location of Death	4c. County of Death Prince George's
Funeral			n(MM/DD/YYYY) 9. Birthplace (State or
Director	220-62-5083 1 M 2 F 51 Yrs.	onths Days Hours Min. MARCH	24,1956 Foreign MARYLAND Country)
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Aaryland 28a-f show 1 at once. ector	MARYLAND CHARLES LA PLATA 10e. Street and Number 10f	Zip Code 10	1 XYes 2 No
is or tiles	POTOMAC STREET		UNITED STATES
or items 23	1 Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (Specify Yes or No- pecify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
safter de	or Dates:	2 X No specify:	Specify: BLACK
hours "naturi Exam	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U.	sual Occupation (Give kind of work done f working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 led within 72 hoursafte ttygiene, other than "natural", the Medical Examiner Completed by	11TH GRADE LABORER		CONSTRUCTION
21215-0036 houldbe filed within 7 to Méntal Hygiene. is marked other than titic eyent, the Medical To Be Comple	17. Father's Name (First, Middle, Last) RICHARD ARCHIE WILLIAMS	18.Mother's Name (First, Middle, MALICE LAVERNE L	
more, MD 21215-003 Pages I and 2 should be filed withinent of Heakh and Manal Hygiene, but I friem 27 is marked other to other traumatic event, the Med To Be Com	19a. Informant's Name/Relationship (Type, Print)	dress (Street and Number of Rural Route Num PLEGREEN LANE, BOWIE,	
nore, MD 2 ages I and 2 shoul nt of Heakh and N nt I friem 27 is n other traumatic	20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery, Date	20c. Location - City or Town, State
Baltimore, permit Pages I an Department of He Important: If ite injury or other transitions of the Important of Important of I	4 Donation 5 Other Specify:	HURCH CEMETERY 9/6/2007	LA PLATA, MARYLAND
Baltimo permit* Page Department of Important: injury or oft	21 Agenative of Funeral Stylice Licensee 22 Name 17HORN LYDIA C. THORNION JOHNSON MOD583 3439	NTON FUNERAL HOME, P.A. LIVINGSTON ROAD, INDI	AN HEAD, MARYLAND 2064
hysician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.		est, shock, or heart Approximate Interval Between Onset and
∠xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death
-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
led Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated		
executed an and al - transit	events resulting in death) Last Due to (or as a consequence or): d		
	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
68760, certificate be nding physici ise as the buri			Month Day Year
). Box 687 the death certific by the attending p ched for use as th	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)	
P.O. that the pred by detach		,	bacco use contribute to the cause of death? 2 V No 3 Probably 4 Unknown
Records, F The law requires ficate has been sig page 2 should be Completed		24a. Was a autop	
Reco			rmed? death?
Vital Rec	25. Was case referred to medical examiner? Hospital: 4 Inpatient 2 M EP/Outpatient 3	26.Place of Death (Check only one) DOA Other Nursing Home 5	Residence 6 Other:
Division of Vital Records, fall or Attending Physician: The law requir rs after death. In Director: After this certificate has been seled in by the funeral director, page 2 should 1 ertification: To Be Completed.	27 Manner of Death 28a Date of Injury 28h Time of Injury	28c. Injury at Work? 28d. Describe t	now injury occurred struck by auto
ivision or Attendi after death Directors I in by the f	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, fa	1Yes 2 V No	Street and Number or Rural Route Number, City
Division o spiral or Attending rours after death, neral Director: After filled in by the fune Certification:	Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town, S	
Division To the Hospian or Aut. within 24 hours after der To the Funeral Direct completely filled in by t Medical Certifica	Certifying Physician: To the best of my knowledge, death occurred (Check only one) Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, and due to the caus in my opinion, death occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To To Gon	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Wie b Lanna	O.C.M.E.	August 30, 2007
B2	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21201	
State Registra	CED II I 2001/1 Man	(i)	
DHMH 17 Rev 1/2001	ORIGINAL	OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 03 0430 Howard D. Wilt, Jr Sept /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 🕱 M 2 🗆 F Director 21 1931 220-34-6282 MD Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show 23a or 28a-f show ust be notified at Director 1 ☐ Yes 2 No Westminster Carroll MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 731 David Avenue "natural", or items 23a di. al Examiner must Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Carroll Landfill Heavy Equipment Operator permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 Is marked other than any injury or other traumatic event. the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora Heiner Howard D. Wilt, Sr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Webster Street Westminster, MD 21157 Gloria K. Bentz/sister Baltimore, 09/06/2007 | 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Valley Cem Pleasant Valley, MD 4 □ Donation 5 □ Other (Specify) Prittes Funerate Home and Chapel, P.A. 21. Signature of Funer Service Licenses 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final An **Physician** disease or condition resulting in death) Acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as \ onsequence of): Examiner certificate be executed burial-transi Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Aother (Specify) Now West Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral L filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical (Check only one) igation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL 30. Name and address of person who complete of death 10 415 31. Date filed (Month, Day, Year) 32. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

07-06735 Erica Weems

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For Regis		Cert	ificate of	Death			J. No.	001 2331
Physician/ ledical Examine	1. De	cedent's Name (First, Middle,La Erica	D. Weems		August 30,	Day Year 2007	1050 1118		
		acility Name (if not institution, gi 654 Howling Point Road			Prince Fr	or Location of I ederick		4c. County of Calvert	
Funeral Director	1	17-78-6896 1	Sex 7. Age (In yrs. last) M 2	st birthday) Yrs		Year If Under:	8. Date of Birth Min. Nov.4		G. Birthplace (State or Foreign Country) MD
w any	10a.	Residence of Decedent State 10b. County		Town or Locati		1			10d. Inside City Limits 1 Yes 2 No
he Maryland or 28a-f show ified at once.	10e.	D Calv Street and Number 6747 Aralia		St.	Leona		10	ig. Citizen of Wha	
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene from 27 is marked other than "natural", or items 23a or 28a-f She trainmatic event, the Medical Examiner must be notified at once the Doctor and Marked has European Director	11. N	Marital Status X Never Married 2 Marrie	12. Was Decedent Ever in U.S		s Decedent of	Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, Black, , etc.
urs after de	3 [1 Yes 2 X No ed If Yes, Give Year or Dates:	16a. Deceder	Yes 2 X	upation (Give ki	nd of work done	Specify:	Black siness/Industry
11215-0036 It be filed within 72 hou fental Hygiene arked other than "natevent, the Medical Exa		ementary/Secondary (0-12)	College (1-4 or 5+)		se Man		121.54		al Health
ore, MD 21215-0036 ges I and 2 should be filed within 7 of Health and Mental Hygiene : If item 27 is marked other than ther trainmatic event, the Medical	a l		E. Weems,		a Addross /6	Rut	Name (First, Middle, Market) h A . er or Rural Route Num	Wall	Lace
MD 21 nd 2 should ath and Me arm 27 is may rumatic ev	R	Informant's Name/Relationship uth A. Weems	/mother		Arali	a Ave:		onard,	MD 20685 City or Town, State
imore Pages 1 nent of H laut: If i	1 4	x Burial 2 Cremation 3 Donation 5 Other Speci	Removal from State S o	Mem.	her place) Gard	ens	9/6/2007	1	
Balt Bermit. Charles Balt Bermit. Import Import injury		Glade a. Sey	well mplications that caused the death.						Home Fred., MD206!
'Medical aminer		failure. List only one cause on nediate Cause (Final disease ondition resulting in death)	each line. a. Multiple Injuries Due to (or as a consequence of	i):					Death .
	if ar cau	nuentially list conditions, ny, leading to immediate se. Enter Underlying Cause sease or injury that initiated ints resulting in death) Last	b. Due to (or as a consequence of c. Due to (or as a consequence of				y_ 29 =	7	er learn
e execut rian and rial - tra	Medical F	UNPENDED	dAMENDED						
teath certificate by eattending physic for use as the bur	23b.	EMALE: Was decedent pregnant in the past 12 months? Yes 2 No 9 V Unknow	23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of de	2 F	etal death other (Specify)	3 Ectopic	pregnancy	, 23d. Date of Month	delivery Day Year
P.O. Box es that the death of	≏ 1		9 Unknown ns contributing to death but not re	esulting in the	underlying ca	use given in Pa	*		ribute to the cause of death?
cords, law requir has been s	Completed						24a. Was autor	osy ormed?	Were autopsy findings available prior to completion of cause of death? Yes 2 No
tal Rec		Was case referred to medical			26.		Check only one)		
n of Vita ding Physicia After this ce	P 27	examiner? 1 ✓ Yes 2 No Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatier 28b. Time of		Other ₄		Residence 6 how injury occur auto collision	
rision or Attending ter death.	Certification:	Natural 5 Pending Accident Investig Suicide 6 Could r	gation 28e Place of Injury - At h	1050 hrs ome, farm, str		Yes 2	c. 28f. Location	Street and Numb	per or Rural Route Number, City
28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Numication 1) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Numication 1) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Numication 1) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide 29g. Certifier 1 Certifying Physician: For est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide 29g. Certifier 1 Certifying Physician: For est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide 29g. Certifier 1 Certifying Physician: For est of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner On the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and place, and one) 2 Medical Examiner On the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and place, and one)									er as stated.
To the within 2 To the complete	Medical (Ch one	 2 Medical Exami D. Signature and title of certifier 	iner:On the pasis of examination a end manner stated.	and/or investig		inion, death oc icense number	curred at the time, date		ned (Month, Day, Year)
	00	Nome and address of a second	ho completed cause of death (Item	n 23a)	(D.C.M.E.		August 31	, 2007
W 10		David Fowler M.D. Cl	hief Medical Examiner	111 Penn	Street, Bal	timore, MD	21201		
Sta Registr	ate 31.	Date filed (Month, Day, Year) 5	2007 32. R gistrar's Signat	B. A	miles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 730 THOMAS J. WALL, SR. Augus7 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University Specialty Hospital Baltimore City If Under 1 Year | If Under 24 H Months | Days | Hours | Mi Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 M 2 □ F 74 164-26-3945 3, 1933 Feb. Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐XYes 2 ☐ No Director MD Worcester Pocomoke City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 130 Eigth Street 21851 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Preacher Ministry 12 Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas Wall Mildred Weaver ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Eigth Street, Pocomoke City, MD 21851 Corrine Wall/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/5/2007 Salem Cem. Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Pocomoke city, MD 21851 A., 103 Linden Ave. Mul Holloway Funeral Home, P.A., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final JRACI URINARY Physician TWOWCO disease or condition resulting in death) /Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, physician s the burial Physician/Medical attending pt for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes certificate 2 No Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) CHRONIC 2
No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Mccriffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certiff D0061765 August 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 WILKERS AVE #307 BALTIMORE MO BA 8 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SFP 0 4 2007 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 24a, perverbal, G871, 9/18/07 CHEPTIFICATE of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9/13/2007 Christine L. Young /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6592 Ashford Lane Frederick Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Hours **Funeral** Days Min. Months 1 □ M 2 🕏 F 170-22-7427 Director 7-30-1923 MD Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 TNo Director MD Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 6592 Ashford Lane death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married "natural", or Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. þ 3 Widowed 4 □ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygid Important: If item 27 is marked other any Injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 <u>James Ewell Harris</u> Christine Lowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ashford Lane Frederick, MD 21702 Christine Young Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Cremation 9/13/2007 | Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee 106 East Church Street Frederick, MD 21701 MO1176 28a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancel Physician 1 1 1 /Medical Due to (or as a sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760. aftending physician Physician/Medical the as IF FEMALE Se 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 No 3 Probably 4 onknown 1 ☐ Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy perform 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

State Registrar

29b. Signatur

and title of certifier

hah

Tham as

29c. License number

12006041

29d. Date signed (Month, Day, Year)

and manner stated.

MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:15P M MARLYN HELEN SCOTT ARMSTRONG September 18, 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UPPER CHESAPEAKE MEDICAL CENTER Bel Air Harford County If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 8. Date of Birth July 3, 1938 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 1 ☐ M 2 💢 F 69 219-38-4014 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 TYes 2 No Maryland | Harford County Jarrettsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2301 Knoll Court 21084 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julian Lamb Scott Julia Lechowicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Scott P. Armstrong (Son) 9236 Countess Drive, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1∏ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. John Ch Cem. Hydes 9/22/2007 | Hydes, Maryland 21. Sq. allin deput of S. Price page MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inflammatory Response Symbour Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? tions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 100 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve once. Pages 1 and 2 should be in

Baltimore,

Armstrang, Martyn

the burial-tran Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p

Completed by Physician/Medical Examiner Be Medical Certification: To

	Part II. Other significant condit
-	
	25. Was case referred to medic

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a.	Cermie
	(Check onl
	one)

2 Accident

4 Homicide

3 Suicide

and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D35012

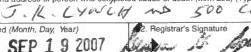
29d. Date signed (Month, Day, Year) September 18,2007

Registrar

31. Date filed (Month, Day, Year)

SEP 1 9 2007

6 Could not be determined



(Type, Print) Chegapeake Drive, Bel Air, Md. 21019

24 hours a

To the l within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are pegible. 29976

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mary B. Annunziato 5:35 A. September 12 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7122 Baltimore Annapolis Blvd. Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 18, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 216 12 9316 1 ☐ M 2 🕱 F 93 Maryland 1914 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Item 27 is marked other than "natural", or itams 23s or 28s-1 show other traumstic event, the Modical Examiner must be notified at Glen Burnie 1 ☐ Yes 2 TNo Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7122 Baltimore Annapolis Blvd. 21061 U.S.A. by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or itemating or other traumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Restaurant 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas Norris Nora Dver ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis G. Tillman / Son 7122 Balto. Annapolis Blvd. Glen Burnie, MD. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 9/17/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Ceron romerous 23a Jart 1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. INPARCION Immediate Cause (Final MYOCARDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed HYDERTENSION Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ CHRONIC OBSTRUCTIVE DULMUNARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1)1513/151 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No Hospital or Attending Physician: After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 9-18-07 ruggy ws.

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

NO- 3721

32. Reditrar's Signature

CITEST. BALTMORE, MI) 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 9 2007

K.S. DIHARMUSTANA

31. Date filed (Month, Day, Year)

	1 - For State Ragistrar		Cei	tificate of	Death		F	lag. No.			
Physician	1. Decedent's Name (First, Middle, La	st)				2	Date of Dea Month	ith Day	Year	3. Time	e of Death
/Medical		beth Alluisi					Septem	ber	14 200		P M
Examiner	4a. Facility Name (If not institution, gir			4b. City, Town,		Death			ounty of Dea		
	Greater Baltimo 5. Social Security Number 6.3	re Medical Cen Sex 7. Age (In yrs.		Towson		4 Hrs. o	Date of Birth		altimo		to or Foreign
uneral irector			75 Yrs.	Months Day		Min.	Date of Birth (Month, Day 7/11/1	Year)		thplace (Star ountry)	
	Usual Residence of Decedent						///	732	Dal	-• Mai	yrand
Important: if learn 27 is marked other then "natural", or iteme 23a or 28a-1 show may injury or other traumatic event, the Medical Examination and single and some and injury or other traumatic event, the Medical Examination and some some and injury or other traumatic event, the Medical Examination and some some some some some some some some	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						i	City Limits
eto octo	Maryland Baltimo	re Ba	altimor	e						1 ⊠ Y	'es 2 □ No
and or tieme 23a or 28a-fe transfer court be rediffed by Funeral Director	10e. Street and Number	-		10f. Zip Code					en of What Co ad Stat		
23a	4213 Harcourt Ro		10		214			OI Vu	nerica		
	11. Marital Status 1 □ Never Married ★ Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2XNo	J.S. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Origi ban, Mexican,	n? (Specif Puerto Ric	ty Yes or No- can, etc.)	14	 Race - Ame Black, Whit 		١.
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 <mark>数</mark> N	Specify:			S	Specify: Wh	nite	
went, the Medical E	15. Decedent's E	ducation	16a. Deced	ent's Usual Occ	upation		1	16b. Kind	of Business	Industry	
M dr	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work don OO NOT use retii	e during most i red)	of working					
S P	12			Clerk				Giar	nt Food	1	
Be	17. Father's Name (First, Middle, Last						First, Middle,				
2	William George De	-					lores I				
Lan	19a. Informant's Name/Relationship Joseph Alluisi/ I	• • • • • • • • • • • • • • • • • • • •		g Address (Stree							
	20a. Method of Disposition	20h F	Place of Disno	Harcour					land 2		
0	1 ☐ Burial 2 ☐ Cremation 3 [Removal from State Fy	cemetery cren 1115 Tun	eral eral el Air	асе) Se	ptemb 7, 20	~ ~ —				
niu.	4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice								t Hill		
eny i	MI + RI	7/	Pé	aceful 7 25 York	Alterna	tives	Funer	cal &	Cremat	ion C	tr., I
	23a. Firt1. Enter the disease, or con-	lications that caused the deat	th. Do not ente	or the mode of dy	ring, such as c	ardiac or r	espiratory arr	est.	COTE ZI	Approxin	nate
sician	Immediate Cause (Final	one cause on each line.									nd Death
dical	disease or condition resulting in death)	aDue to (or as a conseq	nence of).							361	Hours
ner		clostrid	run	diff	ule	col	chis				
je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec		3,0							
ral-transit	that initiated events	c									
burial-transit	resulting in death) Last	Due to (or as a conseq	quence of):								
the but		d									
for use as	IF FEMALE:	00- 16									
for use	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta	al death 3	Ectopic pregnan	су			23	d. Date of del Month	ivery Day	Year
tached hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	ieath 5	Other (specify)							
be detac	Part II. Other significant conditions	ontributing to death but not res	sulting in the un	derlying cause o	iven in Part I.		23e. Did to	bacco use	e contribute to	the cause of	of death?
d b	Penal insu	Skillenan					1 🗆 Y	es 2⊡	No 3□Pr	obably 4	□Unknown
cate has been signed by the ettending page 2 should be detached for use as Compieted by Physician/Me	chronic o	betwichire	wi	og di	seaso	2	24a. Was a	0	24b. Were au	Itoosy findin	os available
page 2	Pulmonar					_	autop	SV	prior to death?	completion o	cause of
ector, pag	25. Was case referred to medical	1198061 100	131001		OC Diago	of Dooth W		2 No	1 🗌 Yes	2□ No	
director.	examiner?	Hospital: 1 Impatient 2	ER/Outpatient	3 DOA	ther		Check only or 5 ☐ Resid		Other (See	0.64	33
	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. ini	urv at		d. Describe h			City)	
a te	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury		ork? ⊒Yes 2.⊟N	0					
tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office	,	28f	Location (S City or Town		Number or Ri	ıral Route N	lumber,
led in by the funera Certification;		building, etc. (opecin				43	City of You	r, State)			
	29a. Certifier 1 Certifying Pl	ysician: To the best of my kno niner: On the basis of examina	owledge, death	occurred at the	time, date and	place, and	due to the c	ause(s) a	nd manner as	stated.	(a)
mpletely fil	5,10)	and manner stated.				Detribute					
	29b. Signature and title of certifier			29c. Licer	nse number				signed (Mont		
8	NO Smann	N (W)			V13:	27	1	01.	-1x	7	
9 9	30. Name and address of person who C. SOMA!VU	~ M)		Do	5134	17		9/1	5-107	7	

State Registrar

31. Date filed (Month, Day, Year) SEP 1 9 2007



ALLUISI, JUNE

07-07178 ¹ Lena R. Buck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ella N. Buck	1- For State Registrar Certificate	of Death	eg. No. 2007 29978
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month September	Day Year 91.15 hrs 1.15 hrs
E) marine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	416 Edgewood Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Birthplace (State or
Director	Q16 Q0 7/97 1 M 2 VF 80 Usual Residence of Decedent	Yrs. Months Days Hours Min. 5/35	1927 Foreign Country) Md
w any	10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show iffied at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	416 Fogewood Street	21009	CLEA
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once ed by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
ral", or	3 Widowed 4 Divorced If Yes, Give Year of Dates:	Yes 2 No specify:	Specify: Black
5-0036 ed within 72 hour 19 ygiene. other than "natu the Medical Exan Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry
215-0036 be filed within 77 mind Hygiene. riked other than ent, the Medical Be Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	Maiden Surname)
21; be fill ked ent,	Withur Dennis	margaret	Floinay 1
MD 21 d 2 should 1 lith and Mer n 27 is man aumatic ev		ling Address (Street and Number or Rural Route Nu	Honor, ma 2/244
more, N Pages I and tent of Health int: If item		position (Name of cemetery, Oate other place)	20c Location - City or Town, State
	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens 2	What and Address of France and Address of France	Daltimese MY
	Payahn (Speine 3	151 Ba Honore Hatt Dines	Saltimore Moralisas
Physician /Medical	Part I. En/or the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiov	a series and the series of	rest, shock, or Meart Approximate interval Between Onset and Death
xaminer	immediate Cause (Final disease or condition resulting in death) a Atherosclerotic cardiov	ascurar disease	
ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause	1.1.2 n ₂	
led nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
executed an and al - transit	d. X UNPENDED AMENDED 77 NO. 070 16)/o/oz mm	
760, icate be execuphysician amothe burial - tr	#23a,27,perME,g872, 10		23d. Date of delivery
b. Box 687(the death certification of the attending ple ched for use as the Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5	Fetal death 3Ectopic pregnancy Other (Specify)	Month Day Year
P.O. Bo that the dea ned by the a detached fo by Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
s, P.C.		1 Ye	es 2 🗸 No 3 Probably 4 Unknown
Division of Vital Records, P.O. tat or Attending Physician: The law requires that the safter death. "Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacler in the funeral of the Completed by Fertification: To Be Completed by Fertilia and the compl		24a. Was auto	
tal Rection: The certificate ector, page	25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	
F Vital Physician This certi	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	I Others	Residence 6 Other: Scene
nding Ph. th. r: After refuneral	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work? 28d. Describe	how injury occurred
Division o spiral or Attending noral safer death. filled in by the func	(Street and Number or Rural Route Number, City		
Di Hospital 24 hours a Funeral 1 ztely filled	Suicide 6 Could not be determined (Specify) 29a. Certifier A Could not be determined (Specify)	or Town,	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transformed for the formal of the	(Check only 1 Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or investiand manner stated.		
F 3F 5 M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Je of	30. Name and address of person who completed cause of geath (Item 23a)	O.C.M.E.	September 16, 2007
12,64	Tasha Greenberg MD. Assistant Medical Examiner 11	11 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	porte	

07-07133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene David A. Bloom 2007 29979 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 13, 2007 1817 hrs Medical Examiner David A. Bloom 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** 4300 Wilkens Avenue Catonsville 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours . Min Director 1 X M 2 North Carolina 219-56-5763 54 02/26/1953 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X'No s 23a or 28a-f show e notified at once. or 28a-f show Baltimore Baltimore Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 4300 Wilkens Ave with Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status "natural", or items | If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces Never Married Married 2 X No Yes Yes 2 X No specify: 4 X Divorced If Yes, Give Year Specify: White <u>ج</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) fimore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hou inhear of Health and Mental Hygiene, rant: If item 27 is marked other than "nat or other transmatic event, the Medical East of or other transmatic event, the Medical East of the All of the contraction of the contraction of the contraction of the Medical East of the Medical Ea Elementary/Secondary (0-12) College (1-4 or 5+) Masonary Mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) rtant: If item 27 is marked y or other traumatic event, Be Howard Anthony Bloom

19a. Informant's Name/Relationship (Type, Print) Doris Jacquline Edmonds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Pennsylvania</u> Tony Bloom 108 Church St. Glen Rock, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Itimore, Barrinoreheorematory Burial 2 X Cremation 3 Removal from State 9/19/07 Baltimore, Maryland Donation 5 Other Specify @Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee that caused the de . Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Ever the disease, or complication failure. List only one caus +on each line. mplications **Physician** Between Onset and **Medical** Death Methadone intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner 24.10 cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed vsician/Medical signed by the attending physician be detached for use as the burial -X UNPENDED #ENDED 7,28a-f, perME, 871, 9/27/07 TT Box 68760. 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? r this certificate h ✓ Yes 2 1 🗸 Yes 2 Νo 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Other₄ examiner? Hospital: Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ۵ 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification 1 Natural Yes 2 X No neral Director: filled in by the f Pending unk Fnd 9/13/2007 | Fnd 6:15 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide or Town, State) 4300 Wilkens Ave. Catonsville 11 within 24 hours a To the Funeral I determined (Specify) house Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 14, 2007 O.C.M.E.

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2007

Ana Rubio MD. 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

Registrar's Signature

State

Registra

		Pleas	se Type or Prin						Are Legible. iene? () () 7	29980
		For State Registrar				rtificate of l		R	eg. No.	
Physicia /Medic	an	1. Decedent's Name (First, Middle,	LARRI	E			LUE	2. Date of Dea Month September	Day th Year	
Examin	er	4a. Facility Name (If not institution, give street and number) SIMPI HOSPITAL OF BALTIMORS				4b. City, Town, or BALTIN		CITY	4c. County of Dea	in
Funeral Director		5. Social Security Number 215-28-2431 6. Sex 1 Am 2 F 7. Age (In yrs. last birthday) Yrs.				If Under 1 Year Months Days		lin. 8. Date of Birth (Month, Day 05/10/	1930 9. Bir	thplace (State or Foreign ountry)
aryland show dat	r	Usual Residence of Decedent 10a. State 10b. County	AL TIMODE	10c. City, To	wn or Lo		-			10d. Inside City Limits 1 ☐ Yes 2 No
h the M r 28a-f r notifie	Funeral Director	MD BA	ALTIMORE	DALI	i Thioi	10f. Zip Code		1	l0g. Citizen of What C	ountry?
ath wit s 23a o nust be	eral D	16 HALCYON COL	JRT 12. Was Decedent	Ever in U.S.	13		21208	(Specify Yes or No-	14. Race - Am	SA erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 🕅 Marri 3 □ Widowed 4 □ Divorced	Armed Forces?			Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	Black, Whi			
"natura	Completed	15. Decedent (Specify only highes	's Education It grade completed)	16	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Business	s/Industry
d withir giene. er than the Me	ошо	Elementary/Secondary (0-12)	College_(1-4or	5+)	,,,,,,	PHYSICIA	•		MEDIC	AL
I be file ntal Hy ed othe event,	Be	17. Father's Name (<i>First, Middle,</i> ALBERT	Last)			BLUE	18. Mother's FANI	Name (First, Middle,	Maiden Surname)	HAHN
should and Me s mark	인	19a. Informant's Name/Relationsh		I '	9b. Maili	ng Address (Street	and Number o	r Rural Route Numbe	r, City or Town, State,	
1 and 2 Health em 27 I		SIMA BLUE / WI	[FE	20h Place	of Dispo	osition (Name of	- :	ALTIMORE,	MD 21208 20c. Location - City o	r Town, State
Pages nent of l int: If its		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				matory or other pla HEBREW C		/18/2007	REISTERSTO	WN, MD
permit. Departm Importa any inju		21. Signature of Funeral Service	Licensee			2. Name and Addre			SON & BROS PIKESVILLE	
Ti.		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each I	ne.					rest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		PTRAT a consequence		n Prie	eumor	TIA		3hrs_
Examiner	<u>.</u>	Sequentially list conditions,		weL a consequence	e ufr	BSTRUC	RION			2 days
cuted and ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Pr	AUCRE	AT	IC CA	NCER			4 yrs.
eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as	a consequenc	ce of):					
certifical ding physe as th	/Medi	IF FEMALE:	23c. If yes, outcome					-	23d. Date of d	elivery
the death by the atten ached for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal dea tt time of death		□Ectopic pregnand □ Other (specify) _	:y		Month	Day Year
w requires that the d been signed by the should be detached	þ	Part II. Other significant condition					ven in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
The law relate has bee	Completed	HYPERCOA	GULABLE	STAT	ϵ			24a. Was autop perfo		
ician: certifica ector, p	Be	25. Was case referred to medica examiner?	Unamitate.		/O. t 1'-	oti Oti	har:	Death Check onl		16 \
ding Physician: The Indiana Th	n: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	28a. Date of In		b. Time	THE SELECT	4 LI NUISI		dence 6 Other (Sp now injury occurred	респу)
Attender death ector:	Certification:	2 Accident investignment in Accident investignment in Accident investignment in Accident investignment in Accident	gation not be 28e. Place of ir		, farm, si	M 1 ☐ treet, factory, office]Yes 2□No		Street and Number or wn, State)	Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	Medical Ce	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examination	dge, dea	th occurred at the t nvestigation, in my	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
To th within To th сопр	Me	29b. Signature and title of certifie	Flor			0.00	se number	0	29d. Date signed (Mo	
10		30. Name and address of person		death (Item 23	Ba) (Type	Print)	AI	OF RAI	TIMORE	
	ate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature	e A	THUSE !!	770	OT DITE	1111010	
Regist	rar	SEP 1	9 2007 1000	in so	Page					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20b&c.perFH,6871, 9/19/07 TT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Butler Physician TEMPER 16, 0140 AM 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death Eacility Name (If not institution, give street and number) Examiner Care NIA East Point If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex 8. Date of Birth **Funeral** 1□M 2**万**F Months Days Hours Min Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltemore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or USA the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 ☐ Divorced þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic even" (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
351 GWYNN AVE. Baltimore, mo 19a. Informant's Name/Relationship (Type. Print) Baltimore, Vineter Crematory of other place) 20b. Place of Disposition (Name of 20a. Method of Disposition - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation / 5 □ Other (Specify) 21. Signature of meral Security 270 Fredhilton 1655 P. March Funeral Home Balto. 23a. Part. En rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Car se (Final disease of or ndition resulting in death) **Physician** /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-trar and P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 autopsy perform certificate 1∏ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0063761 9,18,2007

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

821 N Eutaw St # 308 Baltimore, MD 21021

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. gistrar's Signature

State Registrar

0346

OF MARYLAND

and address of person who completed cause of death (Item 23a) (Type, Print)

UNIVERSITY

32 Registrar's Signature

PETR HAUSNER

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	State of Maryland / Department of Health and Mental Hygie	eneZ (JU	

			State of Maryland / D		li Copies A Iental Hygid	ene 2007 29983
				Certificate of Death	Reg	j. No.
	Physici /Media		1. Decedent's Name (First, Middle, Last) Patrick J. Collins Sr.		2. Date of Death Month Septembe	Pay 14 2007 3. Time of Death 10:40 P M
	Examir	ier	4a. Facility Name (If not institution, give street and number) 124 Chelsea Grove Court	4b. City, Town, or Location of Death Pasdena		4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 212-34-3170 6. Sex 1 7. Age (In yrs. last birth 70 Y	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Feb. 20	(ear) 9. Birthplace (State or Foreign Country) TN
	Maryland f show led at	jo.	Usual Residence of Decedent 10a. State	or Location Pasadena		10d. Inside City Limits 1
	with the l a or 28a- be notifi	Director	10e. Street and Number 124 Chelsea Grove Court	10f. Zip Code	100	j. Citizen of What Country?
	eath ns 23 must	eral	11. Marital Status 12. Was Decedent Ever in U.S.	21122	ooifu Voo or No	USA 14. Race - American Indian,
336	be filed within 72 hours after death with the Maryland Hylgiene. id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify: 	Rican, etc.)	Black, White, etc. Specify: White
215-0036	thin 72 hore. e. an "naturi Medic:i E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing 16	6b. Kind of Business/Industry
	ed wil	Con	Elementary/Secondary (0-12) College (1-4or 5+)	Dealer		Motorcycles
Maryland 2	should be filed ind Mental Hygi marked other umatic event, ti	To Be (17. Father's Name (<i>First, Middle, Last</i>) Unknown	18. Mother's Name	(First, Middle, Ma	
	s 1 and 2 should f Health and Men Item 27 is marke other traumatic			Mailing Address (Street and Number or Rur 4 Chelsea Grove Cour		City or Town, State, Zip Code)
e.	iges 1 and to the if it em		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Coemetery,	Disposition (Name of crematory or other place) Sept	Date 18 20	c. Location - City or Town, State
Ĕ	Pages ment of lant: if its lury or o		4 Donation 5 Other (Specify) Oaklawn	Cemetery 200	7 Ba	ltimore, Maryland
Baltimore,	permit. Pages Department of Important: If It any injury or once.		21. Signature of Funeral S. rvi Licensee	3111 Mountain Road	d, Pasade	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each find. Immediate Cause (Final disease or condition	ot enter the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of			
<i>\</i> .	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Discounties of that initiated events c.):		
رة المرار المرار	ite be executed ysician and ne burial-transit	cal Exa	resulting in death) Last Due to (or as a consequence of):		
0	tificate ig phy as the		- U.			
O. BOX	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the law.	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ν, Γ	es that the ingred by perfection	by Phy	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
cords	v requir				10	2 No 3 Probably 4 ☑Unknown
וומו חפו	n: The lav ficate has nr, page 2	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
5	s certi irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	26. Place of Death	4	
5 :	g Phy ter this neral d	\vdash	27. Manner of Death 28a. Date of Injury 28b. Tir	me of 28c. Injury at	ne 5 MResidence 28d. Describe how	e 6 □Other (Specify) injury occurred
5	endin ath. or: Aff he fur	atio	2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		
2	tal or Att s after de al Directi ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	he Hospi n 24 hour he Funer pletely fill	Medical	29a. Certifier 1	death occurred at the time, date and place, for investigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the Community of the	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty	D50108		9/17/2007
	10				Burnu	MD 21061
	Sta Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 1 9 2007	bad Suile 200 blen	ı	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	larylar	nd / Depa	artment tificate	t of H	ealth a	and M	ental Hy	giene Reg. No.	00	7	29984
ı	Physici	an	Decedent's Name (First, Middle, Last								2. Date of De Sept.		, 20%	aç	3. Time of Death
	/Media		Dolores M. (sept.				10:55pm
	Examir	ier	4a. Facility Name (If not institution, give 321 Nicholson)			Town, or SeX	Location o	f Death			County of i Balti		70
			5. Social Security Number 6. So		ge (In vrs.	last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Bir	1			ace (State or Foreign
	Funeral Director			□ M 2□ X F		O Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Aug • 5	y, 1°9′2	27 M	lary	71and
	Maryland	Director	10a State 10b County MD Baltimo	ore	_	ty, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🎽 No		
	th with the 23s or 28		10e. Street and Number 321 Nicholson	n Road	-		10f. Zip	Code 212	221			10g. Citi	zen of Wha	t Coun	try?
980	72 hours after death with the Maryland Instural', or Items 23s or 28s-f show dical Exactional be notified at	by Funeral	11. Marital Status **Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No			Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes ②☑ No Specify:				ecify Yes or No Rican, etc.))-	14. Race - Black, V Specify: W	White,	etc.
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		dent's Usual Occupation kind of work done during most of working DO NOT use retired) Oll Supervisor				•		nd of Busin		nical Co.		
yland 2	0 = >	To Be C	17. Father's Name (First, Middle, Last) Edward J. Conn								(First, Middle Fial		,		
Mar	nd 2 sho alth and 27 is mu ir trauma		19a. Informant's Name/Relationship (1 Jerry Sawa /r	^{Type, Print)} nephew							Route Numb				
Baltimore,	Pages 1 a ent of Her nt: If item ry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. F	Place of Dispo cemetery, crem K Law	sition (Nam natory or ot n Ce	ne of ther place mete	ery 9	D 718	ate 3/07		cation - Cit Ltimo		
Balti	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic socie.		21. Signature of uneral Service licen	1	1		Name and			30	0 Mac Home				to. MD 21221
	<u> </u>	0	23a. Part. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final	one cause on sach	line.	h. Do not ent	er the mode	e of dying	g, such as o				прас	A	Approximate Interval Between Onset and Death
68760,6	rate be executed /Medical Examiner und prize transit the prirat-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, full list condit	Due to (or a	s a consequence of a co	tos!								6	verio years
O. Box	that the death certificat ed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown								23d. Date of delivery Month Day Year			•
rds, P.	quires that n signed b uld be dete	by	Part II. Other significent conditions co	ontributing to death	ntributing to death but not resulting in the underlying cause given i				n in Part I.		23e. Did t				e cause of death?
Division of Vital Records,	ician: The law requires that the certificate has been signed by th ector, page 2 should be detache	e Completed	OF Was and salared to redire!								1 Tes	osy ormed? 22No	24b. Wer prior deat 1 🗆	to con	esy findings available apletion of cause of
₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpat		ER/Outpatien		Othe	er.		(Check only			-	
lon of	Sing After fune	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury	28b. Time of Injury		Bc. Injury Work	at	2	ne 5 Resi 28d. Describe			Specify)
Divis	o tre	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At he tc. (Specif	ome, farm, str	et, factory,	, office		2	28f. Location (City or To			r Rurai	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier (Check only one)	ysician: To the bes iner: On the basis and manner s	or examina	tion and/or inv	estigation,	in my op	inion, deatl	h occurre	ed at the time.	date and	place, and	due to	ated. the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	H.			29c.	License	number			29d. Date	e signed (A	fonth, E	
}			Farm t. 1	Mue, 1	AD.		1) 0	057	772	21	9	114	+/0	7
	10		30. Name and address of person who co	completed cause of	death (Item	n 23a) (Type, -406 &	Print)	n B	lvd,	Es:	ses M	02	1221	,	
4	Sta Registr		31. Date filed (Month, Day, Year) SFP 1 9 20	32 Regist	rar's Signa	Je Ap	we								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month SEPTEMBER 16, 2007 2:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Min. 1 □ M 2 1 F 221-18-3613 Director 7-1930 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at a or 28a-f shot be notified a Baltimore Director 1 ☐ Yes 2 KINo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemating or other trainments. incolnshire by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delphin Daise ဥ Wilhelmina Farrow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ester Chase-A Baltimore Md 21234 Lincolnshire Ct 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley

Memorial Gardens

22. Name and Address of Facility

Evans Fureral Chapel + Cremation Syrs-Parkville

8800 Harford Pand Darkville Md 21234

Approximate 20a. Method of Disposition 21. Signatury of Funeral Service Licenses 23a. Part1. Enter the discusser or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart from the cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) **Physician** SEPSIS UNKNOWN /Medical Due to (or as a consequence of): Examiner RENAL FAILURE UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed HEPATIC FAILURE UNKNOWN and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical CHOLANGIOCARCINOMA, LIVER UNKNOWN as If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed HYPERCHOLESTEROLEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? es 2X No certificate 1 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of I Director: After the funeral 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Sulcide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760, P.O. Records, or Vital Division

To the Hospital or Attending Physician: within 24 hours aft

To the Funeral Di

completely filled in

10 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE. TOWSON. EDUARDO P. LAYUG

31. Date filed (Month, Day, Year) 3

29b. Signature and title of certifier



and manner stated.

29c. License number

D 24025

29d. Date signed (Month, Day, Year) 09/16/07

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Sandra Dorsey At 200 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore 1919 Hillenwood Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Days Min 1 □ M 2 TF 220-36-1049 12-14-1940 66 **Director** Md. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1√ Yes 2 No Md. Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1919 Hillenwood Road 21239 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: 2 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Citi Financial 12th grade Trader 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Williams Marjorie Cooper ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Derrick Dorsey Son 1919 Hillenwood Road, Baltimore, Md. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ited any Injury or otlonce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 9-25-07 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East /e., Baltimore, Md. 1101 E. North Ave., 21202 a Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes Æ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) SEP 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007

wel.

32. Registrar's Signature

W20396

Division or Vital Records, P.O. Box 68760, ζ or Attending Physician: within 24 hours a

> State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Good Have Ross

29d. Date signed (Month, Day, Year)

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/5, perINF. G872, 10/10/07, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Elma Y. Donohue 9 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 166-14-8357 Date of Birth (Month, Day, Year) Months 1 □ M 2X F 86 Yrs Director 10/27/1920 ₽ennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f sh notified 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Timonium 10g. Citizen of What Country? United States of america 10e. Street and Number 10f. Zip Code тs 23a or ? must be n 12310 Rosslare Ridge Rd. #502 21093 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo
If Yes, Give
Year or Dates: ed other than "natural", or Items event, the Medical Examiner m 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Completed by Specify: white 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be William O. Young Loucinda Umpbly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12240 Roundwood Road Unit 407 Timonium, MD 21093 James L. Donohue Jr./ Son 20b. Place of Disposition (Name of Evans Funeral Chapel – Bel Air 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2012 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 18, 2007 Forest Hill, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. P. 11. Enter the disease, or complicatins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 9/17/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 9 2007 State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

SEPTEMBER 15,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DIN 200 /Medical 4c. County of Death
Beetin 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wardbridge TONSV 116 OK 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Voar Months Hours Min 1 □ M 2 F 238-38-7906 Yrs. Director March 23, 1928 with Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Xes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married 1□Yes DNo Maryland 21215-0036 "natural", or 2 Specify: 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any Injury or other frammer. ervice Elementary/Gecondary (0-12) College (1-4or 5+) Jashie 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental H Pages 1 and 2 should nent of Health and Men ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 832 Winando andas Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City 1 Burial 2 □ Cremation 3 □Removal from State 9-20-67 amel 4 Donation /5 ☐ Other (Specify) 21. Signature of Fareral Service Licenses 22. Name and Address of Facility 23a. Part I Life of discase, or commissions that caused the death. Do not enter the mile of dying, such as cardiac or respiratory arrest, ships, or learn failure. List only one cause on each line. Gary Pimarch Reneral Tome Bacto , md. 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SQUAMOUS TONGUE CARCINOMA **Physician** C ELL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been signated by page 2 should b 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 2 XNo 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Plewithin 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier

State Registrar

29d. Date signed (Month, Day, Year)

D0059107

09-18-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

210 BUSINESS CENTER DRIVE REISTERSTOWN

mp 21136

31. Date filed (Month, Day, Year)

UMA

SEP 1 9 2007

State of Maryland / Department of Health and Mental Hygiene 29990 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9 Day **Physician** 2007^{ea} 16 110p Gardner James /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA Joseph Richey Hospice Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours Min. 1 **X**M 2 □ F 56 Director 2-23-1951 N.C. 212-56-5110 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1**X**Yes 2 □ No Director Md. Baltimore NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 3 21206 USA 4316 Brehms Lane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or ite Iry or other traumatic event, the Medical Examine. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Vincent DePaul Staff Supervisor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Parks Gardner, Sr. Pearlie ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 E. Madison St. Apt. 517, Baltimore, Md. 21205 Pearlie Gardner Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 9-22-07 Randallstown, Md. King Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 21202 1101 E. North Ave., Baltimore, Md. la 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** year disease or condition resulting in death) ung carrie /Medical Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 12 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No OSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ther (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide in 24 hours.
the Funeral Director 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice 838 Eutaw St Baltimore 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2007 Registrar

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	Phys /Me Exa
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

		State of Maryland / Department of Healt		•	•	
		1 - State Registrar Certificate of Deal 1. Decelent's Name (First, Middle, Last)		Reg.	No. 2007	29991
Physici /Medi	cal	William Henry Gross		Month September	Day Year 12 200	
Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat 9 INA I Hospital of Bultamore Dulamore			4c. County of Dea	th
Funeral Director			Inder 24 Hrs. 8	B. Date of Birth (Month, Day Ye	arl Co	thplace (State or Foreign puntry)
Maryland -f show fied at	tor	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
with the 3a or 28a	al Director		2 8	10g.	Citizen of What Co	*
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 □ Never Married 1 □ Yes 2 ☑ No 11. Was Decedent of Hispania if Yes, specify Cuban, Mes		fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) If 6. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	nost of working	16b	Kind of Business	Industry
uld be filed v Mental Hygie irked other itic event, th	To Be Co	17. Father's Name (First, Middle, Last)	Mother's Name (F	First, Middle, Maid		
and 2 sho ealth and I n 27 is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Stury 13) 19b. Mailing Address (Street and Number of Stury 13)	Ω_1	()	ty or Town, State, . KESVIII 2,	Zip Code) MD 21208
Pages 1 ment of Ha ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Q 18	01 B	Location - City or	Town, State
permit Depart Import any inj		21. Signature of Funeral Service Licenses 22. Name and Address of F 8728 Libert	Facility V Cou		reen fur Usturn	was Series
Physician		23a. Part 1. Enter to 1 disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Sep 5/5	ch a ardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner	-	Due to (of as a consequence of): Renal Fallure				months
e be executed sician and burial-transit	sal Examiner					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown			23d. Date of de	livery Day Year
uires that t signed by d be deta	by	The significant conditions continuously to death but not resoluting in the underlying cause given in P	Part I.			o the cause of death?
The law req te has been age 2 shoul	Completed	Atrial Fibrillation		24a. Was an autopsy performed	24b. Were au prior to death?	utopsy findings available completion of cause of
ician: sertifica ector, p	Be	25. Was case referred to medical examiner?	Place of Death (C	1 Yes 2 ✓ Check only one)	No 1 ☐ Yes	2 √ No
nding Phys th. r: After this e funeral dir	tion: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 2 Rose of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Year	280	e 5 ☐ Residence d. Describe how in	e 6 □Other (Spe njury occurred	city)
tal or Atters after dear al Director	Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f	f. Location (Street City or Town, St		ural Route Number,
the Hospli in 24 hour the Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ite and place, and n, death occurred	d due to the cause I at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
With To 1	Σ	29b. Signature and title of certifier At the Manufacture 11 At S	ber - 000		Date signed (Mont	
2		M 100 BOWNING 11. 10			tember 1	1,000+
Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maa Melissa Murillo M. D. Sinai Hospi 31. Date filed (Month, Day, Year) SEP 1 9 2007	1011 1-	DHILIN	0/6	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 20b.perFH.g871, 9/19/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear **Physician** Month /Medical Virginia J. Griffin September17,2007 9:55 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year 8. Date of Birth (Month, Day Year) 1917 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 😾 F 89 212-05-0098 Director New Jersey Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene. ns 23a (must b 323 S. Ellwood Avenue 21224 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home If Item 27 is marked other or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jones Estel Richards ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau once. Henry Endlich/ Husband 323 S. Ellwood Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 09/19/09 Baltimore, MD 4 Donation 5 ☐ Other (Specify) Huner Sen 22. Name and Address of Facility 21. Signatur 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, of c shock, or heart failure. List prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final PNELLMONIA Physician disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 22 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 2 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBEN 17,2007

DHMH 17 Rev 1/2001

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Registrar

State

CHARLES ST, SUITE 216 , BALTIMORE, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DANIEUE DOBERMAN, MO

31. Date filed (Month, Day, Year) SEP 1

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32. P gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 Year **Physician** 69 Ronald K. Geigan /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner City, Town, or Location of Death ssedale Baltimore Franklin Square If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days June 10, 1926 Maryland Hours Min. 1**X**M 2□F 81 219-20-6131 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d Inside City Limits Middle River Baltimore 1 ☐ Yes X No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2234 Redthorn Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Yes 2 Tres, Give Year or Dates 2 No 1 ☐ Yes 2 X No Specify White Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crown, Cork, & Seal Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Kingsley John H. Geigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
704 Pine Creek Ct. Abingdon, MD 21009 19a. Informant's Name/Relationship (Type. Print) Edward Geigan/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Garrison Forest 1 Burial 2 Cremation 3 Removal from State 09/20/07 Garrison, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign way f Furnal Pervice Licens 22. Name and Address of Facility 300 Mace Ave. Balto. MD. Connelly Funeral Home of Essex 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonio Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 ☐ Yes 🍑 No 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

Physician

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certificate has Hospital or Attending Physician: The funeral director. Be Certification: To After this after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours a To the Funeral I 29a. Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 30. Name and address of person who 5 31. Date filed (Month, Day, (aar) State Registrar DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day William C. September 11, 2007 10:03 p^M Gonce 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore County If Under 24 Hrs. 6. Sex If Under 1 Year | Months Days Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1¥ M 2□ F 212-48-9966 62 Jan 16, 1945 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Md. Baltimore County Rosedale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21237 USA 1608 Weyburn Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Funeral Director Mortuary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles R. Gonce Dorothy Dunn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Gonce (wife) 1608 Weyburn Rd. Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Heart of Jesus 9/15/07 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee raminouski 4001 Ritchie Highway Balto. Md. 21225 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) De to (or as a consequence of): menters RAPA mune) month reaction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑*No 3 ☐ Probably 4 ☐ Unknown ntus 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 v No autopsy performed? Yes 2 No Liver transplant in November 2005

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

filed within 72 hours after

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permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra

Maryland 21215-0036

Baltimore,

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To the Funeral Director: completely filled in by the f

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Medical Certification:

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Vital Physician:

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1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of death 9□ Unknown	5 Other (specify)
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and-Strage Liver o	Lisense, secondary to h	epatocellular
	I non alcoholic ster	

Other:

25. Was case referred to medical examiner? To 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending

Но	spital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3 🗆 🛭	OOA
		b. Time of Injury		28

Place of Dea	th (Ci	heck only one)		_ 1 .	
4 ☐ Nursing H	lome	5 Residence	6 dother (Specify)	Hos	pice
	28d.	Describe how inj	ury occurred		

investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At hom building, etc. (Specify) 4 Homicide determined

28c. Injury at Work? 2 No 1 Tyes At home, farm, street, factory, office

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ı	28f. Location (Street and Number or Rural Route Number,
ı	City or Town, State)
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(Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ompleted cause of death (Item 23a) (Type, Print)

29c. License number mo

State Registrar

Date filed (Month, Day, 32. Maistrar's Signature Year)

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		Registrar		Certificate o	of Death		Re	eg. No. 2	101 2999	
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4		4a. Facility Name (if not institution, Howard County Genera			4b. City, Town, or Columbia	Location of Dea	th	4c. County of Howard	Death	
Funeral		5. Social Security Number 6	. Sex 7. Age (In ye	rs. last birthday)	If Under 1 Year			h(MM/DD/YYYY)	9. Birthplace (State or	
Director		214-64-1528 Usual Residence of Decedent	1XM 2 F 5(О у	rs. Months Days	Hours M	08/30	/1957	Foreign Country) MD	
any		10a. State 10b. County	10c. C	City, Town or Loc	ation		•		10d. Inside City Limits	
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h with	Funeral	11. Marital Status	12. Was Decedent Ever in		las Decedent of His Yes, specify Cuban.			14. Race - White,	American Indian, Black,	
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-000 I withing giene.	om	17. Father's Name (First, Middle, L	5+	OWNER		9 Mothor's Nan	ne (First, Middle, M			
	Be C	JACK	•	GOODMAN		CAROLE		naiden Surriame)	SOBLE	
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica	To E	19a. Informant's Name/Relationshi	(Type, Print)		ng Address . (Street			ber, City or Town		
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Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1 X Burial 2 Cremation			osition (Name of cent) CONGREGAT	FTH	Date		City or Town, State	
Itim		4 Donation 5 Other Spe 21. Signature of Funeral Service L		ISRAEL	CONGREGAT Name and Address	of Facility CO	/18/2007	BALTIM	ORE, MD	
Den Perm Depi		Rocard /	7	80	Name and Address	DCTUMN DCTUMN	DUVU - D	INECATII NA 9 RKO	S., INC. E, MD 21208	
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wedical xaminer	1 12	Immediate Cause (Final disease	a. Hypertensive at	heroscler	otic cardiov	ascular o	lisease	C 19G	Between Onset and Death	
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8760, tificate be ng physici as the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p	regnancy				23d. Date of d	•	
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cords, law requir has been s	Completed						24a. Was autop	sy pr	ere autopsy findings available for to completion of cause of	
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n of Vit ling Physic After this funeral dire	٤	1 Yes 2 No		✓ ER/Outpatie		y at Work?		Residence 6	Other:	
Division of Vital Records, P.O. Box 6 tal or Attending Physician: The law requires that the death cer s after death. 31 Director: After this certificate has been signed by the attendited in by the funeral director, page 2 should be detached for use.	Certification:	1 X Natural 5 Pendin				es 2 No	2001 20001120 1	ow many occurre	u	
ViSi or Atte fler de Directo	iţica	2 Accident Investig	28a Place of Injury - A	at home, farm, str	eet, factory, office bu	uilding, etc.			r or Rural Route Number, City	
Dital o	Se H	4 Homicide determ					or Town, S	tate)		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (sician: To the best of my know ner:On the basis of examination					. ,		
To wit Con	Mec	29b. Signature and title of certifier	and manner stated.		29c. License				d (Month, Day, Year)	
6 0			1 / 2 7		O.C.N	л.Е. 00	ME	September		
ex belo	1	30. Name and address of person w	no completed cause of death (II	tem 23a)		-				
WI		Theodore M. King, Jr., I			111 Penn Str	eet, Baltimo	re, MD 21201			
Sta Regist		31. Date filed (Month, Day, Year)	2. Registrar's Sign	lature 1004						
			A. Shanish and	- A						

Physician /Medical **Examiner** the burial-tran physician

Physician

/Medical

Examiner

Funeral

Director

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Important: If item 27 any Injury or other to once.

Director

Funeral

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Baltimore, Maryland 21215-0036

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Physician/Medical Completed by Be Certification: To filled in by 24 hours a

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPSIS AND ACUTE RENAL FAILURE 25. Was case referred to medical 1 XYes 2 No 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

27. Manner of Death 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

RESTOU VICENTE MACO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL OF MARYLAND, 5601 LOCHRAVEN BLVD, BALTIMORE, MD

9/17/07

State Registrar

completely

within 2.

31. Date filed (Month, Day, Year) 19 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Timothy Francis Groesser <u> 2007 2999</u>7 1- For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day Year September 14, 2007 1355 hrs Medical Examiner Timothy Francis Groesser 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** 400 Symphony Circle Unit 328 Cockeysville If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral oreian Months Days Hours Director 215-50-6733 46 Country) Maryland 02/04/1961 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2 X No Cockeysville Baltimore Maryland Director 10g. Citizen of What Country' 10e. Street and Numbe 10f. Zip Code 400 Symphony Circle, Unit 328 21030 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status marked other than "natural", or items c event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married X Yes Yes 2 X No specify: white Specify 4 X Divorced If Yes Give Year ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages I and 2 should be filed within 72 I rent of Health and Mental Hygiene. culinary chef 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Claypoole Be Frank O. Groesser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health and M nt: If item 27 is m other traumatic 21093 Elizabeth G. Gambo/sister Timonium, MD 22 Bussing Ct. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Baltimore, Maryland nent ant: Green Mount Crematory Sep. 18, 2007 Donation 5 Other Specify: 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, 21. Signature of Funeral Service Licensee Baltimore, 6500 York Rd. MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line (Medical Death End stage renal disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed AMENDED 11 per inf, 12 per fh g872 10-31-07 vt #23a, 27, per E, C872, 10/24/07 TT hysician/Medical YUNPENDED tending physician use as the burial The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available certificate has been sector, page 2 should 24a Was an prior to completion of cause of autopsy performed? death? ✔ Yes 2 1 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: director, 25. Was case referred to medical Division of Vital Be examiner? Other, Hospital: Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA Inpatient 2 After this ပ 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No Director: / Pending 24 hours after death. 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 within and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 15, 2007 O.C.M.E. me 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 17,2007 Sept. Patrick Joseph Hollingshead 0216 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death <u> Gilchrist Hospice Center</u> Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days IDM 2□F Hours 215.56.4371 55 10.14.1951 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No MD Baltimore Nottingham 10g, Citizen of What Country? 10e Street and Number 10f Zin Code 24 Cedarcone Ct. U.S.A. 21236 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Mever Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 225No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Courier Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Hollingshead Josphine Quent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Cedarcone Ct. Nottingham, MD 21236 Mary Livingston/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Chesapeake Crem. 09.18.07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee 23a. Part. Littler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alternatives 8717 Green Pastures Dr. MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNI Due to (or a onsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an

Physician /Medical Examiner Examine be executed

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Department or Important If any injury or once.

Physician

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Baltimore,

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Division or Vital Records, P.O. Box 68760,

To the Hosping.

Within 24 hours after death.

To the Funeral Director. Af

Physician/Medical

Be Completed by

Medical Certification: To

25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HDS/ICE 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

D64395

29d. Date signed (Month, Day, Year) SEPTEMBER 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NCHARLES ST. SWIFE 216 BACTIMITE, MO 21204 DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) SEP 1 9 2007 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

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	Funeral Director	iei	5. Social Security Number 6. S 218-32-0898	de	e (In yrs. last birthday 69 Yrs.	Bell	A M D If Under 24 Hrs Hours Min.		ASPFORE	thplace (State or Foreign ountry) RYLAND
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD HARFO	RD	10c. City, Town or L	ocation DARLIN	IGTON			10d. Inside City Limits 1 ☐ Yes 2 🛣No
	h with th	al Dire	10e. Street and Number 1703 GRANITE R	OAD		10f. Zip Code 210	34	1	0g. Citizen of What C	•
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	5		30. Name and address of person who co	completed cause of dea	ath (Item 23a) (Type,	Print)	and A	an mr	7. 2)///4	
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			For State Registrar	State o	f Marylaı		artment of I rtificate of			ental Hyg	giene Reg. No	007	30000
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	the Ho in 24 the Fu	Medical	(Check only 2 Medical one)	Examiner: On the ba and mann	isis of examina	ation and/or inv	estigation, in my o	opinion, deat	th occurred	dat the time, d	ate and p	lace, and due to	the cause(s)
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1	141		30. Name and address of person 2. AUSIM S/A 31. Date filed (Month. Day, Year)	who completed cause	of death (Iten	n 23a) (Type, F	Print) AU DRIVA	Sur	TE 21	22B B	SELE	UR. MI	21014
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